Table of Contents – Chapter 10.000
Administration

10.000 Administration

10.100 Preface

This chapter presents information about this manual. It introduces and describes the Children's Rehabilitative Services (CRS) Program, its financing, organization, and administration in the State of Arizona. It also includes the interfaces between the CRS Program and other state and federal agencies and organizations.

10.101 How to Use the Children's Rehabilitative Services (CRS) Manual

This manual contains the policies and procedures necessary for the operation of Arizona Children's Rehabilitative Services (CRS). These policies and procedures are established by the Arizona Department of Health Services (ADHS)/Office for Children with Special Health Care Needs (OCSHCN/Children's Rehabilitative Services Administration (CRSA) to implement laws and regulations. including pertinent provisions of the Arizona Revised Statutes, Federal Government Regulations, the Administrative Manual of the Arizona Department of Health Services, and such rules, regulations and procedures, as may be established by the Director of the Arizona Department of Health Services.

The chapters in this manual are divided into Sections. Chapters are numbered serially in Arabic numerals. Sections are subsets of chapters numbered serially in Arabic numerals preceded by a decimal. As an example:

10.000 - identifies Chapter as "10"

10.100 - identifies Section as "100"

10.102 Development and Revision of Policies and Procedures

Where there is a conflict between rule and policy, the rule takes precedence. CRSA rules are contained in A.A.C. R9-7-101 to R9-7-705.

All CRS policies and subsequent revisions are to be approved by the CRSA. Policies will be prepared, reviewed, and revised in consultation with the CRSA Medical Director, Regional Medical Directors and Administrators. Parent Action Council members in each region will also be invited to provide input and comments to proposed policies or revisions. The implementation of ADHS/CRS policies shall be coordinated among the Regional Contractors and others, as applicable, to ensure operating consistency throughout the CRS Program. Policies will be reviewed at least annually. Based on the policy reviews, necessary policy revisions will be made in accordance with the above procedures.

10.103 Dissemination of New Policies and Procedures

Upon the development or revision of a policy, notification will be made to all appropriate State agencies, Regional Contractor sites, and regional Parent Action Councils.

10.104 Acronyms

"AAP" The American Academy of Pediatrics.

"ADA" The Americans with Disabilities Act Public Law 101-336 enacted July 26, 1990.

"ADE" The Arizona Department of Education

"ADES" The Arizona Department of Economic Security

"ADHS" The Arizona Department of Health Services, a State agency as defined in A.R.S. Title 36, Chapter 1. Pursuant to A.R.S. Title 36, Chapter 4

"AHCCCS" The Arizona Health Care Cost Containment System, a State agency, as described in A.R.S. Title 36, Chapter 29, which is designated as Arizonaôs Medicaid program.

"AHCCCSA" The Arizona Health Care Cost Containment System Administration.

"ALTCS" The Arizona Long Term Care System, a program in AHCCCS that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by ARS 36-2931 et. seq.

"AMPM" The *AHCCCS Medical Policy Manual.*

"A.R.S." Arizona Revised Statutes.

"AAC" Arizona Administrative Code**:** the state regulations established pursuant to relevant statutes. Relevant sections of the AAC are referred to throughout this document as ñADHS Rulesò.

"BIA" The Bureau of Indian Affairs.

"CDT" Current Dental Terminology.

"CMS" The Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

"COBRA" The Consolidated Omnibus Budget Reconciliation Act.

"CY" Contract year, corresponds to state fiscal year (July 1 through June 30).

"CAP" Corrective action plan.

"CPM" Clinical Performance Measure.

"CPT" Current Procedural Terminology.

"CRS" Children's Rehabilitative Services.

"CRSA" Children's Rehabilitative Services Administration.

"CYE" Contract Year Ended.

"DD" Developmental Disability/Developmental Delay.

"DES" The Arizona Department of Economic Security.

"DES/CMDP" The Comprehensive Medical and Dental Program in the Department of Economic Security, Division of Children, Youth and Families, through which the State provides health care to foster children.

"DES/DDD" The Division of Developmental Disabilities in the Department of Economic Security.

"DUA" Data Use Agreement.

"DME" Durable medical equipment.

"EI" Early Intervention.

"HCFA" Health Care Financing Administration.

"FCC" Family centered care.

"FFP" Federal financial participation.

"HIPAA" Health Information Portability and Accountability.

"ICD-9" International Classification of Diseases-9th revision.

"I.D.E.A." Individuals with Disabilities Education Act.

"LEA" Local Education Agency.

"LEP" Limited English proficiency.

"I.E.P." Individualized Education Plan.

"I.F.S.P." Individualized Family Service Plan.

"ILC" Independent Living Center.

"JCAHO" The Joint Commission on the Accreditation of Healthcare Organizations.

"MED" Medical expense deduction.

"MM" Medical Management.

"NCQA" National Committee for Quality Assurance.

"OCR" Office of Civil Rights.

"PAC" Parent Action Council.

"PIP" Performance Improvement Project**.**

"PHI" Protected Health Information.

"PCP" Primary Care Provider**.**

"PA" Prior Authorization**.**

"PSR" Provider Services Requisition.

"QI" Quality Improvement.

"QMò Quality Management**.**

"QMP" Quality Management Plan

"QOC" Quality of Care.

"SEA" State Education Agency.

"S.O.B.R.A." The Sixth Omnibus Reconciliation Act, 1986 Section 9401, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C., 1396a(a) (10)(A)ii(IX), July 1, 1988.

"SSA" Social Security Administration.

"SSI" Supplemental Security Income.

"SPAC" State Parent Action Council**.**

"TBI" Traumatic Brain Injury.

"TDD" Telecommunications Device for the Deaf.

Definition of Terms

In this policy and procedure manual, unless otherwise specified:

"Abuse" Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the CRS program, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the CRS program.

"Access to Care" A membersô attainment of timely and appropriate health care services.

"Action" The denial or limited authorization of a requested service including:

1. The type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide a service in a timely manner, as set forth in contract; or
5. The failure of a contractor to act within the time frames specified by rule.
6. Denial of a rural CRS memberôs request to obtain services outside the CRS Regional Contractorôs network under 42 CFR 438.52(b)(2)(ii), when the CRS Regional Contractor is the only Contractor in the rural area.

"Acute Health Care" Medically necessary ambulatory, emergency, inpatient, and follow-up health services provided in response to the various stages of disease or injury.

"Administrative Hearing" A hearing under A.R.S. Title 41, Chapter 6, Article 10 (also called State Fair Hearing).

"Advance Directives" Documents written in advance that state your choices for health care, or name someone to make choices about your care if you are unable to make decisions.

"AHCCCS Medical Policy Manual (AMPM)" The AMPM provides information regarding covered health care services for Arizona residents who are eligible for AHCCCS acute and long term care

services.

"Americans with Disabilities Act (ADA)" A Public Law 101-336 enacted July 26, 1990. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation.

"Appeal" A request for review of an action.

"Appeal Resolution" The written determination by the CRS Regional Contractor concerning an appeal.

"Applicant" An individual who has requested enrollment into the CRS program and for which CRS has received a written, signed, and dated application.

"Application packet" The completed documents, forms, and supplemental information necessary to process eligibility for CRS.

"Arizona Administrative Code (AAC)" State regulations established pursuant to relevant statutes. Relevant sections of the AAC are referred to throughout this document as ñADHS Rulesò.

"Arizona Department of Health Services (ADHS)" A State agency as defined in A.R.S. Title 36, Chapter 1. Pursuant to A.R.S. Title 36, Chapter 4, ADHS is responsible for licensure and certification (when applicable) of health care facilities included as AHCCCS-registered providers.

"Arizona Health Care Cost Containment System (AHCCCS)" A State agency, as described in A.R.S. Title 36, Chapter 29, which is designated as Arizonaôs Medicaid program. AHCCCS is composed of the Administration, Contractors and other arrangements through which health care services (acute, long term care, and behavioral) are provided to members.

"Arizona Long Term Care System (ALTCS)" A program in AHCCCS that delivers long term, acute, and behavioral health care and case management services to eligible members, as authorized by ARS 36-2931 et. seq.

"Assess or Evaluate" The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to CRS Regional Contractor service delivery systems.

"Authorization request (expedited)" Under 42 CFR 438.210, means a request for which a provider indicates or a CRS Regional Contractor determines that using the standard timeframe could seriously jeopardize the memberôs life or health or ability to attain, maintain or regain maximum function. The CRS Regional Contractor must make an expedited authorization decision and provide notice as expeditiously as the memberôs health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the CRS Regional Contractor justifies a need for additional information and the delay is in the memberôs best interest.

"Authorization request (standard)" Under 42 CFR 438.210, means a request for which a CRS Regional Contractor must provide a decision as expeditiously as the memberôs health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the CRS Regional Contractor justifies a need for additional information and the delay is in the memberôs best interest.

"Balanced Budget Act (BBA)" of 1997, Public Law 105-33, means the Federal law that increased the attention given to performance monitoring and quality assurance in both Medicaid and the newly created State Children's Health Insurance Program.

"Business day" Monday, Tuesday, Wednesday, Thursday, or Friday unless: a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday; or a legal holiday falls on Saturday or Sunday and a contractor is closed for business the prior Friday or following Monday.

"Capitation" Payment of a fixed monthly payment per person in advance for which the CRS Regional Contractor provides covered services.

"Case Manager" A designated individual who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary health care.

"Children's Rehabilitative Services Administration (CRSA)" A subdivision of the ADHS, which provides regulatory oversight of the CRS Program and the contract processes as they relate to CRS Regional Contractors and the delivery of health care services.

"Children's Rehabilitative Services (CRS)" A program that provides for medical treatment, rehabilitation, and related support services to

eligible individuals who have certain medical, handicapping, or potentially handicapping conditions, which have the potential for functional improvement through medical, surgical, or therapy modalities.

"Claim Dispute" A contested payment of a claim, denial of a claim, or imposition of a sanction.

"CLAS" Standards for culturally and linguistically appropriate services in health care assuring cultural competence in health care.

"Clean Claim" A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

"Co-Insurance" Co-Insurance (coinsurance) a cost-sharing arrangement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. Health care cost which the covered person is responsible for paying, according to a fixed percentage or amount.

"Co-Payment" A cost-sharing arrangement in which the insured pays a specified flat amount for a specific service (such as $10 for an office visit or $5 for each prescription drug).

"Completion/Implementation Timeframe" The date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the CRS Regional Contractor.

"Concurrent Review" The process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care.

"Contract Year (CY)" The time corresponds to state fiscal year (July 1 through June 30).

"Coordination of Care" The process that links children and youth with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

"Co-payment" An amount that the member pays directly to a provider at the time covered services are rendered.

"Corrective Action Plan (CAP)" A written work plan that includes goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timeframes. CAPs are generally used to improve performance of the CRS Regional Contractor and/or its providers, to enhance activities and the outcomes of the activities, or to resolve a deficiency.

"Covered Services" A list of identified health medical services (refer to Chapter 40).

"CRSA Medical Director" The physician designated by CRSA to oversee the medical management portion of the CRS program. The Medical Director reports to the Office for Children with Special Health Care Needs (OCSHCN) Office Chief.

"CRS Clinic" An established clinic held at a Regional Contractor site.

"CRS Condition" A disease or disorder that qualifies for CRS coverage as identified in Chapter 30.

"CRS Credentialed Provider" The CRS Regional Contractors are credentialed as approved by hospital standards.

"CRS Eligible" An individual that has completed the CRS application process, as delineated in this CRS Policy and Procedure Manual, and has met all applicable criteria to be eligible to receive CRS related services.

"CRS Member" An individual who meets CRS eligibility requirements and is enrolled in CRS.

"CRS Provider" A CRS Regional Contractor or its subcontractor who provide CRS covered services to a member.

"CRS Regional Clinic" A multi-specialty interdisciplinary facility that provides CRS services to members.

"CRS Regional Contractor" An entity contracted with CRSA under a capitation arrangement to provide CRS covered services directly or through sub-contractors to CRS members within a specific region of the state or through application of the CRS transfer policy.

"CRS Regional Medical Director" The physician appointed by the CRS Regional Contractor to make medical decisions about the medical eligibility of applicants and the medical care provided to members assigned to the CRS Regional Contractor. The Regional Medical

Director also may provide medical advice and counsel to CRSA and to the CRS Regional Contractor and interface with medical directors of other agencies and health plans on care coordination issues.

"Current Dental Terminology (CDT)" A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

"Current Procedural Terminology (CPT)" A standardized mechanism of reporting services using numeric codes as established and updated annually by the American Medical Association (AMA).

"Cultural and Linguistic Competency" Culturally and linguistically appropriate services CLS means standards to measure the ability of health care provider and health organizations to respond to the cultural and linguistic needs of the patient in health care settings.

"Culture" An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious or social group; the ability to transmit the above to succeeding generations; is dynamic in nature.

"Days" Calendar days unless otherwise specified in the text.

"DES/CMDP" The Comprehensive Medical and Dental Program in the Department of Economic Security, Division of Children, Youth and Families, through which the State provides health care to foster children. CMDP is an AHCCCS Health Plan.

"DES/DDD" The Division of Developmental Disabilities in the Department of Economic Security as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for licensure/certification of facilities for individuals with DD, providers, and the provision of services to eligible Arizona residents with DD. AHCCCS Administration contracts with DES to provide services to its members with DD.

"Deductibles" Amounts required to be paid by the insured under a health insurance contract, before benefits become payable. Usually expressed in terms of an "annual" amount.

"Diagnosis" A determination or identification of a disease or condition that is confirmed by a physician.

"Discharge Planning" A procedure where aftercare services are determined for after discharge from the inpatient facility. Required by Medicare and JCAHO for all hospital patients.

"Disease Management" An integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

1. Identifying and proactively monitoring high-risk populations
2. Assisting members and providers in adhering to identified evidence-based guidelines
3. Promoting care coordination
4. Increasing member self-management, and
5. Optimizing member safety.

"Dual Eligible" An individual who receives both Medicare and Medicaid benefits. Dually eligible people with disabilities usually receive Social Security and Medicare benefits and Supplemental Security Income (SSI) and Medicaid benefits. (The Social Security benefits are usually Disability Insurance benefits or Disabled Adult Child benefits received due to the retirement, death, or disability of a parent).

"Durable Medical Equipment (DME)" Prescribed medical equipment that can be used for an extended period of time.

"Durable Medical Equipment (DME), Customized" Equipment that has been altered or built to specifications unique to a memberôs medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

"Emergency Medical Condition" A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patientôs health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

"Emergency Medical Service" Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These conditions must be met at the time services provided or it is not covered.

"Employee" All officers and employees of the Department and of any local health department, including those who may be loaned or assigned to the Department or local health departments by another governmental or private health agency, including consultants paid on a fee basis by

the Department or a local health department.

"Encounter" A record of a health care related service, which is rendered by a provider, registered with CRS to a CRS member on the date of service, and for which a CRS contractor incurs financial liability. It is submitted by a CRS Regional Contractor to CRSA where it is processed.

"Encounter Data" Data relating to treatment or service rendered by a provider to a patient, regardless of whether the provider was reimbursed on a capitated or fee-for-service basis. Used in determining the level of service.

"Enrolled" Any individual who has completed the application process, attended the first clinic visit, maintains medical/financial requirements, and has signed a CRS payment agreement.

"Enrollment" The process by which an eligible person becomes a member of the CRS program.

"Ex-member" An individual who is no longer enrolled in the CRS Program.

ñ**Family-centered"** Care that recognizes and respects the pivotal role of the family in the lives of children. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the child.

"Federal Financial Participation (FFP)" The Federal matching rate that the Federal government makes to the Title XIX and Title XXI programs in the state of Arizona.

"Filed" The receipt date as established by a date stamp.

"Formulary" An approved list of pharmaceuticals for dispensing for CRS Eligible conditions.

"Fraud" The intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

"Functional Status" A measure of an individual's ability to perform normal activities of life.

"Genetics" The studies of how particular traits are passed from parents to

children. Identifiable genetic information receives the same level of protection as other health care information under the HIPAA Privacy Rule.

"Grievance" An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to:

1. The quality of care or services provided; and
2. Aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrolleeôs rights.

Grievances do not include ñaction(s)ò as defined in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

"Guardianship" A person authorized under state or other law to act on behalf of the member in making health-related decisions. Examples: a parent acting on behalf of an un-emancipated minor or a parent who has petitioned for guardianship for their 18-21 year old member.

"Handicapping" Physical impairments that limit one or more major life activity such as: caring for oneself; performing manual tasks; walking; seeing; hearing; speaking; breathing; learning; and working.

"Health Care Professional" Under 42 CFR 438.2, means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed certified social worker, registered respiratory therapist and certified respiratory therapist technician.

"Health Information Portability and Accountability Act (HIPPA)" of 1996, Title II Subtitle F published by the United States Department of Health and Human Services means the administrative simplification provisions and modifications thereof, and the Administrative Simplification Compliance Act of 2001.

"Health Plan" An organization, now referred to as an Acute Care Contractor, which contracts with the AHCCCS Administration to administer the provision of a comprehensive package of AHCCCS covered acute care services to enrolled AHCCCS members.

"Home Health Services" In accordance with 9 A.A.C. 22, means the services provided by a home health agency that coordinates in-home intermittent services for curative and/or habilitative care. This includes home health aide services, licensed nurse services, medical supplies, equipment and appliances.

"Hospital" A health care institution licensed as a hospital, as defined in ARS § 36-2351.

"Independent Living Center (ILS)" Peer support and resources for transitioning youth with special needs.

"Inpatient" An individual who has been admitted at least overnight to a hospital for the purpose of receiving diagnostic, treatment, observation, or other CRS services.

"Interdisciplinary team" A team of health professionals from various disciplines and family members who collaborate in planning, delivering, and evaluating health care services.

"KidsCare" Arizona Children's Health Insurance Program, funded through Title XXI of the Social Security Act and state funds, also referred to as Title XXI. The KidsCare Program offers comprehensive medical preventive and treatment services and a full array of behavioral health care services statewide to eligible children under the age of 19.

"Local Health Department" Any district,, county, or city health department or any combination thereof.

"Medical Assistance" The Title XIX portion of the AHCCCS program, which also includes S.O.B.R.A.

"Medical Assistance Financial Screening Form" The DES document that identifies potential Title XIX eligibility.

"Medical Expense Deduction (MED)" A Medicaid eligibility category for a Title XIX Waiver member whose family income is more than 100% of the Federal Poverty Level (FPL) and has family medical expenses that reduce income to or below 40% of the FPL.

"Medical Foods" A metabolic formula or modified low protein foods that are produced or manufactured specifically for members with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder.

"Medical Home" An approach to providing comprehensive health care. A medical home is defined as care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.

"Medical Information" All clinical records, medical reports, laboratory statements or reports, any file, film, record or report, or oral statement

relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects, and associates of communicable disease patients.

"Medical Management (MM)" An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).

"Medical Staff" All physicians and dentists employed by or under contract with CRS.

"Medically Necessary" As defined in A.A.C R9-22-101.B. means a medically necessary covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life.

"Member" Is synonymous with the terms enrollee and insured. A member is any individual who is enrolled in the CRS Program.

"Member Abuse" Any intentional or reckless infliction of physical harm, injury caused by a negligent act or omission, unreasonable confinement, emotional or sexual abuse, or sexual assault to a CRS enrolled member.

"Methodology" The planned process, steps, activities or actions taken by a CRS Regional Contractor to achieve a goal or objective, or to progress toward a positive outcome.

"Minor" An individual who is:

1. Under the age of 18 years;
2. Incompetent as determined by a court of competent jurisdiction; or
3. Incapable of giving consent for medical services due to a limitation in the individualôs cognitive function as determined by a physician.

"Monitoring" The process of observing, evaluating, analyzing and conducting follow-up activities.

"Multi-specialty" The use of more than one specialty physician or dentist in the treatment of a member.

"Notice of Action" Written notification to the member/representative of an

action that the CRS Regional Contractor has taken or intends to take.

"Notice of Appeal Resolution" Written notification to the member/ representative and other parties of the decision made by the CRS Regional Contractor of an appeal.

"Notice of Decision" Written notification to the provider and other applicable parties of the decision made by the CRS Regional Contractor regarding a claims dispute.

"Notice of Denial" Written notice to the applicant/representative of the decision of the CRS Program to deny enrollment.

"Notice of Eligibility Decision" Written notification to the member/ representative and other parties of the decision made by the CRS Regional Contractor of an eligibility decision.

"Notice of Hearing Request" Written notification to the CRS Regional Contractor that a member/representative or provider has requested an Administrative Hearing.

"Objective" A measurable step, generally in a series of progressive steps, to achieve a goal.

"Office of Civil Rights (OCR)" The office is part of HHS. Its HIPPA responsibilities include oversight of the privacy requirements

"Out of Network" Care provided by health care providers that are not a part of the CRS Regional Contractor provider network.

"Out of Network Referral" A provisionally covered benefit that requires prior authorization by CRS Regional Contractors for referrals to providers or facilities that are not in the network to satisfy unique health care needs of a CRS member.

"Outcome" A defined outcome that is the result of an intervention.

"Outcome Measurement" System used to track interventions and resulting outcomes.

"Outpatient Services" Health care services rendered to members who are not hospitalized.

"Outreach Clinic" A clinic designed to provide a limited specific set of services including evaluation, monitoring, and treatment in settings geographically closer to the family than a CRS Regional Clinic.

"Parent" A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.

"Parent Action Council (PAC)" The regional council consisting of family members, parents, or legal guardians of children, who are, or have been, CRS members, or adults who are or were members. The Parent Action Council also includes professionals, advocacy groups, CRS Regional Contractor representatives, and ADHS/CRSA staff.

"Partial Transferò Assignment of a member to two or more CRS Regional Contractors.

"Payment Responsibility" The portion of the cost of CRS services that a member or family has agreed to pay, according to a signed Payment Agreement.

"Pediatric Transition to Adulthood" All youth with special health care needs receive the services they need to make necessary transitions to all aspects of adult life, including adult health care, work and independence.

"Peer Review" The review and evaluation of a practitionerôs professional actions related to care of CRS members, by a selected peer group.

"Performance Measurement" Defining a target goal and measuring the effectiveness of interventions on a projected outcome

"Physician" An individual currently licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Post Stabilization Services" Medically necessary services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition or to improve the memberôs condition.

"Practice Guidelines" The description of medical practices that assist clinicians in making appropriate decisions regarding health care.

"Primary Health Care" Routine health care provided to prevent disease, treat injury or maintain general health.

"Primary Care Provider (PCP)" An individual responsible for the primary management of the memberôs health care, as defined in 9 A.A.C. 22, Article 1. The PCP must meet the requirements of A.R.S. §36-2901.

The PCP must be an individual, not a group or association of persons, such as a clinic.

"Privacy" For purposes of the HIPAA Privacy Rule, an individual's interest in limiting who has access to personal health care information.

"Prior Authorization (PA)" The process by which a CRS Regional Contractor determines in advance whether a service is medically necessary... Prior authorization is not a guarantee of payment.

"Protected Health Information (PHI)" Under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form.

"Privacy Notice" The CRS Regional Contractor must give notice describing practices regarding protected health information. The CRS members must obtain signed acknowledgements of receipt (also known as notice of privacy practices).

"Provider" A person or entity that subcontracts with a CRS Regional Contractor to provide CRS covered services directly to members.

"Provider Network" A person or entity who agrees to the terms specified in the contract with the CRS Regional Contractor.

"Provider Services Requisition (PSR)" A request from a health care provider to a CRS Regional Contractor for prior authorizing a service.

"Quality Improvement (QI)" The systematic application to assess and improve internal operations.

"Quality Management (QM)" The review of the quality of health care provided to CRS members.

"Qualified" An individual meets the conditions, criteria, or requirements for enrollment in the CRS Program.

"Quality of Care Concern" There is possibility that an action could negatively impact the memberôs health care status.

"Rehabilitation Act of 1973" First major legislative effort to secure an equal playing field for individuals with disabilities. This legislation provides a wide range of services for persons with physical and mental impairments. The Rehabilitation Services Administration (RSA) administers the Act. Two Sections have immense regulatory impact on accessible Web design. These are Section 504 and 508.

Section 504 of the Rehabilitation Act - Nondiscrimination Under Federal Grants and Programs.

"Reinsurance" A method of limiting the financial risk of providing services by purchasing insurance that becomes effective after set dollar amount has been reached.

"Reliability" The degree to which the measure is free from random error and the results are reproducible.

"Residence" The place where an individual lives.

"Resident" An individual who is living in Arizona and can provide proof of residency.

"Retrospective Review" The process of determining the medical necessity of a treatment/service post delivery of care.

"Sanction" Reprimand that for breaking a law or rule resulting in financial penalties.

"School" Any public or private institution offering instruction to students of any age.

"Scope of Service" The medical services covered under the CRS Program.

"S.O.B.R.A." The Sixth Omnibus Reconciliation Act, 1986 Section 9401, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C., 1396a(a) (10)(A)ii(IX), July 1, 1988. This program provides Medical Assistance to eligible pregnant women as soon as possible following verification of pregnancy, and provides Medical Assistance to as many eligible children born on or after October 1, 1988, as is possible.

"Special Health Care Needs" Serious congenital or chronic physical, developmental, or behavioral conditions that require medically necessary health and related services of a type or amount beyond that required by children generally. All CRS members are considered to be members with special health care needs.

"Specialty Physician" A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.

"Social Security Administration (SSA)" The Federal agency that administers

SSI, SSDI, and related programs.

"Supplemental Security Income (SSI)" The Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing, and shelter.

"State, the" The State of Arizona.

"State Parent Action Council (SPAC)" The state council consisting of family members, parents, or legal guardians of a child who is, or has been, a CRS member, or adults who are or were members. The SPAC includes professionals, advocacy groups, Regional Contractor representatives, and CRSA staff.

"Telehealth" The use of telecommunications (i.e., wire, internet, radio, optical or electromagnetic channels transmitting text, x-ray, images, records, voice, data or video) to facilitate medical diagnosis, patient care, patient education, and/or health care/medical learning (member not present).

"Telemedicine" The delivery of diagnostic, consultation and treatment services that occur in the physical presence of the member on a real time basis through interactive audio, video and data communications, as well as the transfer of medical data on a store and forward basis for diagnostic or treatment consultations.

"Termination Date" The date that a member is no longer eligible for services.

"Timely Appointment" An appointment timeframe that, if not met, may adversely affect the health of an enrolled member.

"Title V" The federal statutes governing the Maternal and Child Health Program, which is a public health service of the U.S. Department of Health and Human Services.

"Title XIX" The Federal Medicaid Program, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services to help those families and individuals become or remain independent and able to care for themselves.

"Title XXI" The State Childrenôs Health Insurance Program (SCHIP), Title

XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage. In Arizona, the SCHIP program is known as KidsCare.

"Tracking of Disclosures" he HIPAA Privacy Rule gives individuals the right to request an accounting of disclosures of protected health information over the previous six years.

"Total Transfer" The assignment of a member to a different CRS Regional Contractor.

"Treatment Plan" A written plan of services and therapeutic interventions based on a comprehensive assessment of a member's developmental and health status, strengths, and needs that are designed and periodically updated by the interdisciplinary team.

"Trending" The method of estimating needs and costs of health services by reviewing past trends in cost and utilization of these services. Trending also means analysis of data to identify potential issues.

"Utilization Management/Review" The CRSA and the CRS Regional Contractorôs process to evaluate appropriateness, efficacy and efficiency of medically necessary services.

"Youth" An individual over the age of 14 years but less than 21 years of age.

10.200 Introduction to the CRS Program

The following section provides an overview of CRS Program mission, goals, objectives, and general information about the organization and operation of the CRS Program. This section also contains information about services, providers, contractors, and the role of other state and federal agencies in CRS funding and oversight.

10.201 Mission, Goals and Objectives of the CRS Program

Mission

The mission of Arizona Children's Rehabilitative Services (CRS) is to improve the quality of life for children by providing family-centered medical treatment, rehabilitation, and related support services to enrolled individuals who have certain medical, handicapping, or potentially handicapping conditions.

Goal

The goal of the CRS Program is to provide quality care through early detection, prevention, comprehensive medical treatment, and rehabilitation to enrolled individuals with handicapping or potentially handicapping conditions.

Objective

The objective of CRS is to assure the highest quality comprehensive care for the functional improvement of medically qualified individuals through a family-centered, multi-specialty interdisciplinary team approach in a cost effective managed care setting.

10.202 Program Description and Organization

Program Description

CRS serves individuals under 21 years of age residing in Arizona, who meet the criteria established by CRSA. A combination of funding is received from state and federal sources. CRSA collects federal funding from the Arizona Health Care Cost Containment System (AHCCCS) Administration for Title XIX categorically eligible AHCCCS members and for Title XXI eligible members who are enrolled in the State Childrenôs Health Insurance Program known as KidsCare. CRSA also receives funding through the Title V Maternal and Child Health Block Grant for Title V eligible persons.

CRS provides for medical treatment, rehabilitation, and related support services to individuals who have certain medical, handicapping, or potentially handicapping conditions, which have the potential for functional improvement through medical, surgical, or therapy modalities. CRS provides these services through regional service contracts, where the approach to service delivery is family-centered, coordinated, culturally effective, and considers the unique needs of eligible persons. CRS is not a primary care provider. Each individual is expected to have a primary care provider from which to receive primary health care. The CRS clinic may provide a list of resources to individuals or families who do not have a primary care provider.

Program Organization

The Bureau for Maternal and Child Health is responsible for CRS at the federal level. This bureau is in the Public Health Service of the U.S. Department of Health and Human Services (PHS/DHHS), which oversees the Arizona Department of Health Services (ADHS). ADHS is responsible for the administration of the CRS Program as stated in Article 3, A.R.S. § 36-261, 262. ADHS coordinates, as applicable, with other State agencies to fulfill this requirement.

At the State level, CRSA operates within the Office for Children with Special Health Care Needs (OCSHCN), within Public Health Prevention Services within the ADHS. ADHS is responsible for employing a CRSA Medical Director and an OCSHCN Administrator for CRSA who shall have duties and titles as fixed by the ADHS Director.

CRSA is responsible for: monitoring and evaluating services provided by private contractors; keeping statistical data on the CRS population; providing support and consultant services; and ensuring overall program management and planning.

CRSA solicits contracts from qualified offers to provide CRS services in specific geographic regions of Arizona. These CRS Regional Contractors are responsible for the administration and delivery of CRS services for their own contracted region. CRS Regional Contractors develop and maintain a provider network of specialty physicians, personnel, and facilities to meet the CRS minimum requirements. CRS Regional Contractors may determine the appropriate reimbursement methods and amounts for their contracted provider network. CRSA oversees the performance of the CRS Regional Contractors. The CRS Regional Contractors are subject to contractual requirements, and follow policies and procedures, administrative rules, and laws.

10.203 Governing Statutes and Regulations

Federal

Title V, Part 2, of the Social Security Act (the Act) contains the general provisions setting up the powers and functions of the Social Security Administration, which may provide Title V federal funds to CRS. Part 2 makes provision for the appropriation and allocation of certain sums of money to the various states.

The Act requires that each state shall submit a plan for services for CRS individuals which will provide for financial participation by the State; administration of the plan by a state agency or supervision of the plan by a state agency; and appropriate methods of administration and reports. The Secretary of the Department of Health and Human Services must approve a state plan before federal subsidies can be provided to fund the CRS Program.

Funding will be denied should the Secretary of Health and Human Services find that the state operation of the CRS Program does not comply with the rules and regulations set down by the Social Security Administration.

Title XIX of the Act establishes the Medicaid program, which is a national health care program providing Medical Assistance to families and to aged, blind and disabled individuals whose income and resources are insufficient to meet

the cost of necessary medical services. The program is administered by the Centers for Medicare & Medicaid Services (CMS) of the federal Department of Health and Human Services (DHHS). Medicaid is a state/federal partnership under which the federal government establishes basic program rules. Each state must submit a State Plan describing how it will administer the Medicaid program within the confines of federal rules governing the program.

In Arizona, the Medicaid program is known as the Arizona Health Care Cost Containment System (AHCCCS). Federal Medicaid funding is available for all Medicaid-covered services rendered to enrolled CRS members who are federally eligible and enrolled in AHCCCS, in accordance with Arizona's Medicaid State Plan. Many children who are CRS members are concurrently enrolled in AHCCCS. The AHCCCS Administration also oversees the delivery of health care services funded by Title XXI, the State Children's Health Insurance Program. In Arizona, this program is known as KidsCare. Children who are medically qualified for CRS may also be enrolled in KidsCare. The CRS Administration works closely with the AHCCCS Administration to ensure CRS service delivery requirements are consistent with Medicaid and KidsCare requirements.

State

In accordance with the provisions of the Social Security Act, administration of the CRS Program in Arizona has been assigned by the Legislature to the ADHS.

Enabling legislation for CRS is found in Article 3, A.R.S. §§ 36-261 and 36-262. Enabling legislation for the care, treatment and reimbursement to the Department for individuals with sickle cell anemia is set forth in Article 13, A.R.S. §§36-797.43 and .44, respectively.

The adopted Rules for CRS are set forth in A.A.C., Title 9, Chapter 7, Articles 1 through 7.

10.204 Program Qualification Overview

Any individual may be referred to CRS. To be considered for the CRS program the applicant must:

1. Have a CRS medical condition;
2. Meet the age requirement;
3. Meet residency requirements in the state of Arizona; and
4. Provide documentation of legal residency in the United States.

Once these requirements are met, the amount of the member's payment responsibility is determined, based on the family's income and resources. Refer to Section 20.000 for enrollment requirements.

To be enrolled in the program, a member of the CRS professional staff shall evaluate the individual in a CRS pediatric screening clinic or specialty clinic. The physician or designee determines/verifies if the individual has a handicapping or potentially handicapping condition that qualifies for treatment in the CRS program.

10.205 Program Services

CRS Program services are set forth in A.A.C., Title 9, Chapter 7, Article 5, Section 501. Specific policies relative to CRS services are presented in Chapter 40.000 of this manual.

10.206 CRS Providers

The licensure and certification requirements for CRS providers are as follows:

1. Physicians and dentists must be licensed in the State of Arizona.
2. Nurses must be licensed in the State of Arizona.
3. Social Workers must be licensed in the State of Arizona.
4. Audiologists must maintain a current Arizona Audiologist license.
   A. If non-certified or clinical fellowship year (CFY) personnel are utilized, they must be under the direct (onsite) supervision of an Arizona licensed audiologist.
2. Speech-Language Pathologists must maintain a current Arizona Speech-Language Pathologist license.
3. Orthotists and prosthetists must be certified by the American Board for Certification in Orthotics and Prosthetics.
4. Hearing aid dispensers must be licensed in the State of Arizona.
5. Pharmacists must be licensed in the State of Arizona.
6. Psychologists must be licensed by the State of Arizona Board of Psychologist Examiners.
7. Physical and occupational therapists must be licensed issued by the Arizona Board of Physical Therapy and the Arizona Board of Occupational Therapy, respectively.
8. Other Ancillary personnel must be licensed or certified if required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards.

Any individually contracted specialist such as a physician, dentist, psychologist, etc. who provides services to individuals enrolled in federally funded programs must be an AHCCCS registered provider in addition to their licensing requirements.

Facilities providing CRS services shall be licensed by the ADHS and Medicare certified by CMS, and/or accredited by the JCAHO, Accreditation Association for Ambulatory Health Care (AAAHC), or other nationally recognized accrediting body within two (2) years of licensure.

Primary and secondary level hospital services are provided by all CRS contract hospitals. Tertiary level hospital services are provided by Central and Southern facilities. Tertiary care is defined as cardiac or other medical/surgical services, which may require pediatric intensive care.

10.207 Communication of Changes In Program or Provider Network

Changes in program requirements for providing services, maintaining and reporting data, and complying with contractual agreements must be communicated by CRSA to the CRS Regional Contractors with sufficient time to accommodate the change, but no less than thirty (30) calendar days prior to the date the change is to go into effect unless required by law to be enacted sooner. Notification of the change must be in writing and the expected date of compliance must be included.

Any change in a CRS Regional Contractorôs ability to comply with contractual requirements, including provider network changes, must be communicated to CRSA in writing together with the plan for accommodation of members who may be deprived of services, within one (1) business day of the inability to comply being identified in accordance with Chapter 80.600.

CRS Regional Contractors must give written notice about the termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each recipient who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(5)]. This notice must be provided to CRSA within one (1) business day.

CRS Regional Contractors must notify providers and recipients in writing thirty (30) calendar days prior to the effective date of a program change or any other change in the network, excluding a provider leaving the network. The notification letter must be submitted to CRSA forty five (45) calendar days prior to the effective date of the change for review and approval. [42 CFR 438.10(f)(4)].

10.208 CRS Program Funding

Federal Participation in the CRS Program

Under Title V of the Social Security Act, Congress may annually appropriate funds for statesô programs for children with special needs. The federal law requires that out of this appropriation, the Secretary of the Department of Health and Human Services must allocate by statutory formula based on member of low income children and other factors a fixed amount to each state. A minimum of thirty percent mix allocation must be used for children with special health care needs. The State, in accepting these federal funds, agrees to conform with the

details of the State Plan for the provision of CRS authorized services. The State Plan is approved by the Secretary of Health and Human Services (HHS), to conform with the federal regulations applicable to state plans. As a condition of accepting federal funds, CRSA agrees to conform to all applicable federal regulations. The Secretary may also grant portions of the federal funds to individual special projects for the provision of specialized services to children.

Under Title XIX of the Act, federal funding is available for Medicaid-covered services provided to Title XIX categorically eligible individuals in the form of Federal Financial Participation (FFP). Each state has an established Federal Medical Assistance Percentage (FMAP) amount that is paid by DHHS for most Medicaid program expenditures, although that amount may be higher for certain types of expenditures.

In the State of Arizona, the AHCCCS Administration (AHCCCSA) has been designated as the single State agency to receive and distribute Title XIX and Title XXI funds. ADHS has an Interagency Service Agreement (ISA) with the AHCCCSA regarding the CRS programôs use of Title XIX funds for the treatment of CRS conditions. To receive federal reimbursement for CRS services, CRSA shall submit financial reports and encounter data for the provision of CRS authorized services to AHCCCS no later than 30 days following each reporting period, as stipulated in the ISA between the AHCCCS Administration and ADHS. AHCCCS claims FFP from CMS and is required under the terms of its ISA with CRSA to pass through federal monies to CRS.

State Participation in the CRS Program

The State must participate in the financing of CRS according to the Social Security Act, Title V, Part 2, § 513.

The amount of State money available for CRS is determined annually through the Appropriations Act. CRSA receives AHCCCS funds and non-AHCCCS funds as two separate appropriations for program support. CRS receives State dollars for the ñstate matchò needed in order to claim FFP.

Family Participation in the CRS Program

Individuals/families shall participate in a financial interview with a CRS Regional Contractorôs staff member and/or onsite representative of the Department of Economic Security (DES) to determine the individual/family's payment responsibility. The payment responsibility is determined by comparing the family adjusted gross income to the current Federal Poverty Level limit amounts for income and family size.

Members who do not have a payment responsibility include the following:
1. Wards of the State or of the Court;

2. DES/Comprehensive Medical and Dental Program (CMDP) foster children;
3. DES adoption subsidy children; or
4. Children who are Title XIX or Title XXI eligible.

See Payment Responsibility Section, 20.500 and A.A.C. R9-7-207.

10.209 Statewide CRS Medical Directors'/Administrators' Meetings

Meetings of the CRSA Medical Director and CRS Administration along with CRS Regional Contractorsô Medical Directors and Administrators provide an ongoing mechanism for the development and review of CRS policies and procedures, as well as the discussion and resolution of other contractual, programmatic, or operational issues regarding the CRS program. The meetings offer a forum for CRS Regional Medical Directors and Administrators to provide guidance and advice to CRSA Program Management and to review and comment on issues having statewide impact on regional program operations. Each Region has an opportunity to review and provide input to proposed policies and procedures before they are approved and implemented.

Meetings

The CRS Regional Medical Directors and Administrators shall meet with CRSA representatives no less than four times per year. Additional meetings may be requested by any member of the team to address major CRS Program issues having a significant impact on the delivery of care and/or regional program operations. The Administratorsô Meeting includes CRSA Administration, CRS Regional Contractor Administrators, and parent representation from the Parent Action Council (PAC). The Medical Directorsõ/Administratorsô Meeting includes CRSA Administrator, CRSA Medical Director, CRS Regional Contractor Medical Directors, Regional Contractor Administrators, and parent representation from the (PAC).

10.300 Interagency Coordination

It is the policy of the CRS Program to coordinate with other State and Federal agencies in the provision of services for CRS members.

10.301 AHCCCS Administration and AHCCCS Health Plans

CRS members may be concurrently enrolled in an AHCCCS acute care health plan or with an ALTCS Program Contractor, or a KidsCare Program (administered by AHCCCS) to receive acute or long-term care health services. CRS Regional Contractorsô staff coordinates care for members with staff of AHCCCS plans and program contractors and other insurers as needed and appropriate.

The AHCCCS Administration is responsible for determining member eligibility for Title XXI and for the ALTCS program. CRS is subject to AHCCCS rules and policies as they apply to CRS members enrolled in Title XXI programs.

10.302 Arizona Department of Economic Security (DES)

The Arizona Department of Economic Security is responsible for determining member financial eligibility to federally funded programs such as Title XIX. CRS is subject to AHCCCS rules and policies as they apply to CRS members enrolled in Title XIX programs.

The CRS Program coordinates treatment and service delivery with other agencies such as Arizona Early Intervention Program (AzEIP) and the Department of Developmental Disabilities (DDD) for identification, diagnosis, and treatment.

10.303 Department of Education

ñState Educational Agency (SEA)ò is an organization governing every school district in each state and is autonomous with individual school districts, known as ñLocal Education Agency (LEA)ò. The Local Education Agency is a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary or secondary schools. The Local Education Agency includes:

- An educational service agency,
- Any other public institution or agency having administrative control and direction of a public elementary or secondary school, including a public charter school that is established as an LEA under State law; and
- An elementary or secondary school funded by the Bureau of Indian Affairs, not subject to the jurisdiction of any SEA other than the Bureau of Indian Affairs, but only to the extent that the inclusion makes the school eligible for programs for which specific eligibility is not provided to the school in another provision of law and the school does not have a student population that is smaller than the student population of the LEA receiving assistance under this Act with the smallest student population.

10.304 Indian Health Services, Fee for Service

CRS Regional Contractors may coordinate with the Indian Health Service (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Regional Contractorsô staff coordinates care for

members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to IHS fee for service rules and policies as they apply to CRS members.

10.305 IHS AHCCCS

CRS Regional Contractors may coordinate with Indian Health Services (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Regional Contractorsô staff coordinates care for members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to AHCCCS rules and policies as they apply to CRS members.

10.306 IHS Tribal Health Services

CRS Regional Contractors may coordinate with Indian Health Services (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Regional Contractorsô staff coordinates care for members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to identified tribal entity rules and policies as they apply to CRS members.

Identification of ñPotential Healthcare Needsò means ADHS, BH, RBHAôs, Oral Health, OWCH (school readiness board), newborn screening, chronic disease, WIC, Immunization, OCSHCN, Sickle Cell, School Nurses, Asthma Coalition, Federally mandated programs, and Governors Council (Head, Spine, DD).

Table of Contents - Chapter 20.000

Enrollment Requirements

20.000 ENROLLMENT REQUIREMENTS

20.100 Preface

ADHS/CRS serves individuals from birth to 21 years of age who reside in the State of Arizona and who have a CRS condition. CRS conditions and excluded conditions are detailed in Chapter 30.000. This section presents information on the eligibility and enrollment requirements for the CRS program. It describes:

1. The eligibility determination process:
   A. Preliminary determination of medical eligibility,
   B. Age requirements,
   C. Residency requirements, and
   D. Citizenship requirements;
2. Enrollment documentation requirements for:
   A. Applicants enrolled in Title XIX/XXI programs and
   B. Non-Title XIX/XXI applicants;
3. Enrollment interview;
4. Attendance at an enrolling clinic visit, and
5. Income and payment responsibility determinations.

20.200 Referral to CRS

Referrals to ADHS/CRS are initiated by submitting a CRS Application Form. The CRS Application Form can be obtained from many sources including physiciansô offices, the web (www.azdhs.gov/phs/ocshcn, click on CRS, and then click on CRS Referral Form in English or Spanish) and the CRS Regional Contractor locations. The CRS Application Form may be faxed, mailed, or delivered in person to one of the CRS Regional Clinics.

1. The CRS Application Form shall contain the following:
   A. The name, address, and phone number of the referral source;
   B. The relationship of the person completing the application to the applicant;
   C. The name and sex of the applicant;
   D. If the applicant is a child, the name of at least one parent of the applicant;
   E. The address and phone number (home and work, if applicable) of the applicant or, if the applicant is a child, the address of at least one parent of the applicant;

F. If known to the referral source:

1) The applicant's date of birth;

2) The applicant's diagnosis; and

3) The applicant's primary care physician or, if the applicant does not have a primary care physician, the name of a health care organization at which the applicant receives medical care; and

4) If the individual previously received covered CRS medical services the year in which the individual received the services, and the CRS Regional Contractor responsible for providing the services.

2. Documentation to accompany application form:

A. For an applicant who is enrolled in Title XIX or Title XXI has other health insurance, or does not have health insurance but has been evaluated by a physician, the following are required:

1) Documentation from a physician who has evaluated the applicant, stating the medical diagnosis the physician gave the applicant;

2) Diagnostic test results that support the medical diagnosis the physician gave the applicant.

B. If the applicant is not enrolled in Title XIX or Title XXI, or other health insurance, and if a physician has not evaluated the applicant, documentation of the reason the referral source believes the applicant may be eligible for CRS.

C. If the applicant is not enrolled in Title XIX or Title XXI, or does not have other health insurance, and has been evaluated by a physician:

1) Documentation from the physician who evaluated the applicant, stating the individualôs diagnosis made by the physician; and

2) If available, diagnostic test results that support the applicantôs diagnosis.

20.300 Eligibility Requirements

20.301 Age

An individual must be under twenty-one years of age.

20.302 Citizenship

An individual must:

A. be a U.S. citizen;

B. be a qualified alien who meets the requirements of A.R.S. § 36-2903.03(B); or

C. be a non-documented alien who was enrolled in CRS prior to August 5, 1999.

20.303 Residency

An individual who is a resident of Arizona and intends to remain in Arizona.

20.400 Preliminary Determination of Medical Eligibility

The CRS Application Form and any required medical documentation (see Section 20.200) shall be completed and submitted to the CRS Regional Contractor for a preliminary determination of medical eligibility.

CRS Regional Medical Director or designee will review the Application Form and medical records, if available, to determine medical eligibility based on the conditions identified in Chapter 30 of this manual.

With regard to a Title XIX/Title XXI program member, the CRS Regional Medical Director shall respond promptly to an urgent request from an ALTCS/Acute Care Contractor Medical Director to discuss a memberôs medical eligibility for CRS and specific medical circumstances relative to enrollment.

20.401 Notification of Preliminary Determination that an Applicant May be Medically Eligible

1. If the CRS Regional Medical Director or designee makes a preliminary determination that an applicant may be medically eligible for CRS, the CRS Regional Contractor shall, within 14 calendar days from the receipt of the completed CRS referral, notify the referral source; applicant, or if a minor, the applicantôs parent; and, in the case of applicants enrolled in Title XIX/ XXI programs, the applicantôs ALTCS/Acute Care Contractor and referring physician in writing of the determination.
2. The following is included with the written determination:
   - A. Authorization for an initial medical evaluation at a CRS clinic for final determination of medical eligibility for CRS;
   - B Notice that the applicant/family is required to have an enrollment interview before or on the day of the initial medical evaluation;
   - C. The address and telephone number of the CRS Regional Clinic that received the referral; and
   - D. The address, date, and time of the applicant's initial evaluation appointment and the procedure for rescheduling the appointment if the applicant is unable to keep the scheduled appointment. (The initial evaluation appointment must be scheduled for a date within

30 calendar days of the notification of preliminary medical determination.)

E. An overview of CRS; and

F. A list of documentation to be brought by the applicant/family to the enrollment interview:

1) For applicants enrolled in Title XIX/XXI programs, the notification will instruct them to bring the following to the enrollment interview:

a. The applicantôs AHCCCS ID Card;

b. A photo identification of the applicant, or if the applicant is a minor, of the parent or guardian;

c. Guardianship papers (if applicable), and

d. An insurance card if the applicant has other insurance in addition to AHCCCS coverage.

2) Applicants not enrolled in Title XIX/XXI programs should bring proof of eligibility and documentation required for a financial screening and classification.

a. A list of the items accepted as proof of eligibility is to accompany the notification (See Section 20.503);

b. A list of the required records for the financial screening (See Section 20.502); and

c. Notification that the application will be withdrawn after the initial evaluation, if the applicant does not supply the proof of eligibility and financial status within 10 days of the visit, with the option that the applicant may re-apply.

d. If Arizona Department of Economic Security (DES)-FAA eligibility representatives are not present at the CRS Regional Contractor site, the CRS staff are to assist the applicant with completing Medical Assistance application forms and submitting them to DES-FAA.

Prior to a Medical Assistance application being submitted to FAA, ensure that the applicant has signed and dated the application. Gather the necessary verifications, e.g., income, citizenship, identity, age, address. Citizenship verification may be copied by the CRS designee, but the copies must

be stamped ñDES-Copy of Originalò, and include the date and name of the person making the copies. The CRS designee will fax the completed application, any copies of verification, and the completed *Children's Rehabilitative Services (CRS) Referral Application Process Turn Around Document (TAD)* (Attachment A) to the FAA local office which serves the applicantôs zip code within 24 hours of receipt. The TAD is a form used to expedite CRS applications. With the use of the TAD, eligibility will be determined within 10 business days of receipt of the application in the local office versus the standard 45 business days. The applicant will be contacted by FAA if additional information or verification is required.

Once the eligibility determination has been completed by FAA, a notice will be sent to the applicant. FAA will complete the DES portion of the TAD received from CRS and fax it to the CRS designee at the fax number listed on the TAD.

20.402 Incomplete Application

1. If a CRS Regional Medical Director or designee receives an incomplete application and is unable to make a preliminary determination for medical eligibility, the CRS Regional Contractor shall, within 14 calendar days from the receipt of the incomplete application, send a written notice to the referral source; applicant or parent; and, if the applicant is enrolled in a Title XIX/XXI program, the ALTCS/Acute Care Contractor, which shall:
   A. Identify the missing documentation or information the CRS Regional Contractor requires for a preliminary determination of medical eligibility for CRS to comply with A.R.S. § 41-1092.03;
   B. Request the missing documentation or information be submitted to the CRS Regional Contractor within 30 calendar days from the date of the notice; and
2. If the CRS Regional Contractor does not receive the requested documentation or information within 30 calendar days from the date of the notice, the CRS application shall be considered withdrawn.
3. If the CRS Regional Contractor receives the requested information within 30 calendar days from the date of notice, the CRS Regional Contractor shall determine whether the individual is eligible for CRS and notify the referral source; applicant, or if a minor, the applicantôs parent; and, if the applicant is enrolled in a Title XIX/ XXI programs, the ALTCS/Acute

Care Contractor in writing of the determination within 14 calendar days from the receipt of the requested documentation/information.

20.403 Medical Eligibility Denial

1. If a Regional Medical Director determines that an applicant is not medically eligible for CRS, the CRS Regional Contractor shall, within 14 calendar days from the receipt of the completed application, send a written notice that the applicant is not medically eligible for enrollment in CRS to the applicant/family and the referral source. The notice will include instructions on how the applicant can request an Administrative Hearing (see Section 20.1100).
2. For Title XIX/ XXI enrolled members a copy of the denial notification must be sent to the ALTCS/Acute Care Contractor and referring physician within 5 days of the denial.

20.404 Data Sharing with ALTCS/Acute Care Contractors

In addition to sending copies of the medical eligibility notices discussed above to the ALTCS/Acute Care Contractors for Title XIX/ XXI enrolled applicants, the Regional Contractors will exchange data, as specified by the AHCCCS/CRS Task Force, with the ALTC/Acute Care contractors.

20.500 Proof of Eligibility and Financial Application and Documentation Required for Applicants Not Enrolled in Title XIX/XXI Programs

An applicant not enrolled in Title XIX/XXI programs, who refuses to cooperate in the eligibility screening and financial application process will have the CRS application withdrawn and shall not be considered eligible for CRS services. The family/applicant will be informed that they may re-apply to CRS when they are prepared to complete the application process.

20.501 Financial Application Form

1. Non-Title XIX/XXI CRS applicants who meet the preliminary determination for CRS medical eligibility and seek to apply for CRS shall submit to a CRS Regional Contractor a financial application containing the following:
   A. The applicantôs name, address, telephone number, and/or message number;
   B. If the applicant is a child, the name, address, telephone number, message number, employer/work address if applicable, of at least one parent of the applicant;

C. The applicantôs social security number if the applicant has a number;

D. Whether the applicant is covered by health insurance;

E. If the applicant is covered by insurance:

1) The primary companyôs name, billing address, and telephone number; and

2) The applicant's policy or plan number, ID number, group name, group number, end date and coverage type;

F. If the applicant has secondary insurance:

1) The secondary insurance companyôs name, billing address, and telephone number; and

2) The secondary insurance company policy or plan number, ID number, group name, group number, end date and coverage type.

G. Number and identification of members in the household.

2. The financial application shall be signed and dated by the applicant or, if the applicant is a child, the signature of at least one parent of the applicant.

20.502 Documentation to Determine Financial Classification

1. Applicants not enrolled in Title XIX/ XXI programs shall bring the following documentation to the enrollment interview:

A. Documented evidence of all unearned income received by an individual, such as cancelled checks or court orders for child support payments;

B. Documented evidence of all medical expenses incurred by an individual and paid during the 12 months before the date on the application form; and

C. Documented evidence of all unpaid medical expenses.

D. If an individual in the household is employed, supply copies of the individualôs:

1) Pay stubs for the 30 calendar days before the date on the applicantôs application forms;

2) Most recent W-2 form; and

3) Federal tax return most recently filed by the individual.

E. If an individual in the household income group is self-employed, the individualôs:

1) Federal tax return, including a schedule C, most recently filed by the individual; and

2) Most recent quarterly financial statement signed and dated by the individual.

F. Documentation of any dependent care expenses.

G. Documentation of any employee expenses.

2. In addition, if applicable, the applicant shall also bring documented evidence of:

A. Any court award or settlement related to the applicantôs CRS condition, and any expenditures from the court award or settlement made for medical services.

20.503 Proof of Eligibility for Applicants not Enrolled in Title XIX/ XXI programs

1. Applicants who **are not** enrolled in Title XIX/ XXI programs, who meet the preliminary determination for CRS medical eligibility, and seek to apply for CRS shall present to a CRS Regional Contractor proof of eligibility as follows:

A. One of the following as proof of age:

1) A hospital record of birth;

2) A certified copy of a birth certificate;

3) A military record;

4) A notification of birth registration;

5) A religious record;

6) A school record;

7) An Immigration and Naturalization Service record;

8) A federal or state census record; or

9) A United States passport.

B. One or more of the following as proof of meeting the citizenship requirement:

1) A certified copy of a U.S. birth certificate;

2) A naturalization certificate reflecting U.S. citizenship;

3) A current or expired U.S. passport;

4) A certificate of U.S. citizenship;

5) A U.S. Citizen ID card used by USCIS;

6) A final adoption decree;

7) An extract of a U.S. hospital birth record established at the time of birth (must have been created at least 5 years before initial AHCCCS application date); or

8) A life, health, or other insurance record showing U.S. place of birth (must have been created at least 5 years before initial AHCCCS application date).

C. One of the following as proof of residency in the form of:

1. A rent or mortgage receipt for property located in Arizona, where the applicant lives;

2. A lease for property located in Arizona where the applicant lives;

3. A written statement confirming residence at an Arizona nursing care institution under A.R.S., Title 36, Chapter 4, signed by the administrator of the Arizona nursing care institution;

4. An unexpired Arizona motor vehicle operatorôs license;

5. A current Arizona motor vehicle registration, issued within 12 months from the date of an application for enrollment in CRS;

6. Pay stub from an Arizona employer;

7. A utility bill for property in Arizona, where the applicant lives;

8. A current phone directory listing for a telephone located at property in Arizona;

9. A United States Post Office record reflecting an Arizona residence;

10. A certified copy of a church record reflecting an Arizona residence;

11. A certified copy of a school record reflecting an Arizona residence; or

If none of the documents in subsections (C1) through (C11) are available; and the applicant/individual resides in Arizona, the applicant, or if the applicant is a minor, the applicantôs parent or legal guardian, signs an affidavit certifying the individual is currently an Arizona resident and intends to remain in Arizona.

20.600 Enrollment Interview for New Applicant

Every CRS applicant, or if the applicant is a minor, the parent of the applicant, shall participate in an enrollment interview with a designated CRS Regional Contractor or designee. The CRS Regional Contractor or designee shall conduct the enrollment interview in the manner that is most efficient, timely, and considerate of the applicant/parent needs.

20.601 Enrollment Interview Requirements for a Title XIX/ XXI Enrolled Applicant

1. The interview will consist of a comparison of the information and documentation presented by the applicant (AHCCCS ID, parent photo ID, any other insurance cards and applicable guardianship papers) to information in the AHCCCS PMMIS system. If the applicant presents information that is inconsistent with PMMIS, the Regional Contractor may assist the member in resolving the issue with DES (Title XIX) or AHCCCSA (Title XXI) but should rely on PMMIS as the authoritative source when submitting member information to CRSA.
2. If the CRS Regional Contractor is able to verify that the applicant is enrolled in Title XIX/XXI and under 21 years of age according to PMMIS, the CRS Regional Contractor shall consider the applicant eligible for enrollment into CRS pending the diagnosis verification through the first clinic visit.
3. If the CRS Regional Contractor verifies Title XIX/ XXI program membership but finds the applicant to be over 21 years of age, the CRS Regional Contractor or designee shall:
   A. Send a written notice of denial to the applicant/parent with instructions on how to request an Administrative Hearing;
   B. Rescind the authorization for the applicant's initial CRS clinic visit; and
   C. Notify the ALTCS/Acute Care Contractor of the CRS denial due to the applicant being over 21 years of age. (Refer to ACOM Policy 409)
4. AHCCCS enrollees shall not be required to sign a payment agreement for CRS covered services, but shall be required to sign an Assignment of Benefits Agreement.

20.602 Enrollment Interview Requirements for Applicants Not Enrolled in Title XIX/ XXI Programs:

1. All non-Title XIX/XXI applicants must participate in the enrollment interview and, if they are determined through the interview to be

potentially eligible for Title XIX or Title XXI programs, they must apply for those programs before they can be accepted into the CRS program.

2. The Enrollment Interview will begin with a review of the evidence provided by the applicant to prove age, citizenship, and residency.

   A. If the CRS Regional Contractor or designee determines that the applicant does not meet the age, citizenship, and residency requirements for CRS, the CRS Regional Contractor or designee shall:

      1) Send a written notice of non eligibility to the referral source, applicant/parent/guardian; and

      2) Rescind the authorization for the applicant's initial CRS enrollment visit.

3. If the Regional Contractor finds that the applicant meets the requirements for age, citizenship and residency, the Contractor will begin the financial screening which will consist of:

   A. Determining applicant/family's adjusted gross income as detailed in Section 20.603, 5.;

   B. Dividing the adjusted gross annual income as determined above by 12 to arrive at a household monthly income amount for comparison with the AHCCCS Eligibility Requirements found on the AHCCCS web page under Members and Applicants/Income Requirements.

      Comment [KMJ1]: This is all in 20.603

      1) If the applicantôs household income falls into the KidsCare (Title XXI) Category on the Eligibility Requirements chart, then the Special Requirements on the chart will be matched against the information supplied by the applicant regarding employment and insurance, and if the applicant appears to meet the requirements, the applicant will be referred to AHCCCSA to complete a KidsCare application process.

      2) If the applicant falls into any of the AHCCCS (Title XIX) income categories for children, women, families or individuals based on the Regional Contractorôs preliminary financial review, the application process for Title XIX through the Department of Economic Security (DES) enrollment will be explained, and the applicant/family will be given the option of completing the Medical Assistance Application at the CRS Regional Contractor site.

4. If the applicant is scheduled for an initial enrollment clinic visit on the same day as the CRS financial interview and has been unable to provide

information to complete financial screening, the applicant/family will be advised they:

A. May attend the initial enrollment clinic appointment;

B. May be financially responsible for any diagnostic testing; and

C. Will not be allowed future clinic visits until the financial eligibility is complete.

5. If the applicant does not complete the Medical Assistance Application at the CRS Regional Contractor Site, the applicant shall be advised to notify DES, for Title XIX, or AHCCCSA, for Title XXI, that he or she is a CRS applicant when completing the application process to prevent delays in CRS enrollment Applicant must submit a completed application to the Department of Economic Security or the AHCCCSA within 10 working days of the CRS enrollment interview.

6. All medical assistance applications completed at the CRS Regional Contractor site should be stamped on page one with a ñCRSò stamp to clearly identify the applicant as CRS eligible.

7. If the applicant/family chooses to complete the Medical Assistance Application at the CRS Regional Contractor site, the CRS Regional Contractor or designee shall assist the applicant in completing the application using DES criteria for earned and unearned income and income deductions and:

A. The CRS Regional Contractor shall contact the DES representative to assist in determining Title XIX eligibility on the same day as the CRS financial interview; and

B. When DES cannot determine eligibility on the same day as the applicant's CRS financial interview, the CRS Regional Contractor will follow-up in ten (10) business days from the date of the referral by checking the AHCCCS PMMIS system or DES Interactive Voice Response (IVR) system for eligibility status. If the status is un-determined, the applicant's DES representative shall be contacted to determine medical assistance, eligibility/enrollment.

C. If the memberôs eligibility status in PMMIS or the DES IVR system is un-determined at that point, the Regional Contractor shall follow up with DES again within thirty (30) days to check the status of enrollment.

D. If found ineligible for Title XIX due to excess income, the application shall be referred by DES to Kids Care to check for potential eligibility.

8. For the applicant/family found to be potentially eligible for Title XXI (Kids Care), and whose application was forwarded to AHCCCSA, the Regional Contractor shall contact a representative from the Title XXI (Kids Care) office within ten (10) business days following the referral to Title XXI to determine eligibility/enrollment. If Title XXI (Kids Care) status remains un-determined, the Regional Contractor shall follow up within thirty (30) days to check the status.

9. For tracking and reporting referrals, the Regional Contractors shall use the forms supplied by CRSA according to the directions from CRSA.

10. If the applicant is not financially eligible for Title XIX or Title XXI programs, the CRS Regional Contractor or designee shall complete the financial eligibility interview according to the CRS program standards to determine member payment responsibility. These applicants may take additional income deductions, beyond those allowed in determining Title XIX or XXI eligibility, to calculate their adjusted gross household used to determine their State Only financial category. These deductions are:

    A. Health insurance premiums paid by the household income group within the previous twelve months.

    B. Unpaid medical and dental expenses incurred by any individual in the household income group prior to the date of application or at the time of redetermination, which are the household's responsibility and not subject to any applicable third party payment.

    C. Medical and dental expenses paid directly by the household income group for any household individual during the twelve months prior to the date of application and not subject to any applicable third party payment.

11. If the applicant/parent fails to provide financial information or documentation as requested to the CRS Regional Contractor or designee, within 10 business days after the initial financial interview, the CRS Regional Contractor shall consider the application to CRS withdrawn and notify the applicant/parent in writing that they can reapply to the CRS program.

12. If an applicant is found to be potentially eligible for ALTCS, the CRS Regional Contractor or designee shall assist the applicant/family with the ALTCS referral process. If the applicant is later deemed ineligible for ALTCS, the applicant/family shall remain eligible for CRS services according to the initial payment agreement, and Paragraph 10 above shall apply.

20.603 Adjusted Gross Income

1. Household Income Group

In order to calculate the CRS applicant's or member's payment responsibility, use the income of the applicant's or member's household. (See A.A.C. R9-7-602) The following individuals, when residing together, constitute a CRS household income group:

1) A married couple and children of either or both parents;
2) An unmarried couple and the children of either or both parents;
3) A married couple when both are over the age of 21 years;
4) A married couple when either one or both are under age 21 years with no children;
5) A single parent and his/her children;
6) An applicant or a member between the ages of 18 years and 21 years;
7) A child who does not live with his/her parent; and
8) An individual who is absent from a household shall be included in the household income group if absent:
   a. For 30 days or less;
   b. For the purpose of seeking employment or to maintain a job;
   c. For service in the military; or for an educational purpose and the applicant's parent claims the child as a dependent on the parent's income tax return;
9) The following individuals shall also be included in a household income group when the child is not living in the household:
   a. The individual contributes to the income of the household;
   b. The parent of the child claims the child as a dependent on the parent's income tax return for the current year; or
   c. If the parents do not claim the child as a dependent for tax purposes and the child lives with an individual other than the parents, the household income group is the individual's household with whom the child lives.

2. Unearned Income

Unearned income is defined as monies received for which no labor was expended. When payment from any unearned income source is reduced due to a prior overpayment, only the portion actually received will be considered. The following list includes types of unearned income, which, unless otherwise specified, shall be counted in the month of receipt. The list also includes exclusions or other treatment of unearned income amounts that vary depending on whether the program applied for is Title XIX or Title XXI.

1) Agent Orange settlement fund payments are excluded.

2) Alaska Native Regional and Village Corporation Payments. Exclude the first $2,000 per calendar year for Title XIX and Title XXI persons.
3) Aleutian and Pribilof Islanders Relocation Payments are excluded.
4) Alimony or Spousal Maintenance payments are counted as unearned income. Alimony or spousal maintenance payments are court-ordered support payments, which a legally divorced or separated person pays to the spouse.
5) AmeriCorps Network Program benefits are excluded.
6) Assistance Payments are excluded. Assistance Payments are payments received from Arizona or Temporary Assistance for Needy Families (TANF) payments from another state. Arizona assistance payments programs include, but are not limited to, TANF, General Assistance, Tuberculosis Control, and Emergency Assistance.
7) Bureau of Indian Affairs (BIA)
    a. BIA General Assistance Payments are considered to be public assistance payments and are excluded.
    b. Tribal Work Experience Program or Tribal Assistance Project Program. The portion of the income, which is an incentive payment, is disregarded.
    c. BIA or Tribal Work Study Program provides for educational and living expenses. Only payments for living expenses, which are paid directly to the student, are counted as unearned income.
8) Burial benefits dispersed solely for burial expenses.
9) Child Support is any payment received from an absent parent. Child support does not have to be court ordered. An amount in excess of $50.00 per child of child support received in a given month shall be counted as unearned child support income.
10) Cash contributions from agencies or organizations other than the ADHS or AHCCCS are excluded if the contributions are not intended for the following items:
    a. food;
    b. rent or mortgage payments for shelter;
    c. utlities;
    d. household supplies such as bedding, towels, laundry, cleaning, and paper supplies;
    e. public transportation fares for personal use;
    f. basic clothing or diapers; or
    g. personal care and hygiene items, such as soap, toothpaste, shaving cream, and deodorant.
11) Contributions and Complementary Assistance

a. Cash contributions from relatives and other persons shall be counted as unearned income if not considered as gifts or child support.
b. A household member who is receiving SSI may voluntarily contribute to the household. In order for this contribution to be considered unearned income:
   i. The contributor shall not be a person whose income would be required to be included in the individual/familyôs adjusted gross income if he/she were not receiving Supplemental Security Income (SSI);
   ii. The contributor's income is not otherwise considered available to be included in the individual/familyôs adjusted gross income; or
   iii. The contribution shall be for other than the contributorôs share of household expenses.

12) Disaster Assistance.
   1. For Title XIX (Medicaid) payments are excluded;
   2. For Title XXI (Kids Care) payments are counted as unearned income.
13) Earnings from high school on-the-job training programs are excluded.
14) Earned income of a dependent child who is a student enrolled and attending school at least half-time as defined by the institution is excluded.
15) Educational Benefits. The amount of the loan, grant or scholarship remaining after subtracting applicable deductions is averaged over the period of months which the loan, scholarship, or grant is intended to cover. The resulting monthly income shall be counted as unearned income.
16) Educational grants or scholarships funded by the United States Department of Education or from a Veterans Education assistance program or the Bureau of Indian Affairs student assistance program are excluded.
17) Energy Assistance Payments from federal government programs that provide assistance to prevent fuel-cut offs and promote energy assistance are excluded.
18) Fair Labor Standard Act supplemental payments are excluded.
19) Food Stamps and other food programs are excluded.
20) Foster Care Payments.
   a. Payments are excluded for Title XIX (Medicaid);
   b. Payments are counted as unearned income for Title XXI (Kids Care).

21) Emergency Assistance Payments received directly by an applicant or recipient of TANF are excluded.
22) Housing Assistance from U.S. Department of Housing and Urban Development (HUD) is excluded.
23) Indian Gaming Profit Distribution is counted as unearned income.
23) Indian Payments to Specific Native American Tribes or Groups under Public Law are excluded.
24) Individual Development Account. Funds set aside in an individual Development Account under A.A.C. R6-12-404 are excluded.
25) Industrial Compensation payments made by agencies in the Arizona Industrial Commission, similar in other states concerning workers injured on the job, are counted as unearned income.
26) Insurance payments or benefits shall be counted as unearned income in accordance with the following:
    a. Insurance payments made directly to the insured shall be counted;
    b. Insurance payments designated as payment for a specific bill, debt, or estimate shall be counted; and
    c. Insurance benefits that are used for, or are intended to meet, basic daily needs shall be counted.
27) Interest, Dividend, and Royalty payments are made directly to the individual (i.e., interest from checking or savings accounts). Funds left on deposit or converted into additional securities shall be considered a resource and not counted as income.
28) Japanese American Restitution Payments are excluded.
29) Lease or Royalty from Indian Land. On some reservations, individuals own or are allotted part of the reservation land that they may lease to others depending on the agreement with the tribe or stipulations on the land. In addition, in some areas, an individual family may own land that is not part of the reservation, in which case the family may lease the land. All of these land lease situations shall be treated as follows:
    a. All land lease income shall be counted; and
    b. The frequency of the land lease income varies, as follows:
        i. Land lease income shall be counted when it is received by the BIA and posted to the individualôs account, making the funds available for pick-up by the individual;
        ii. If land lease income is available every month, the income shall be counted monthly;
        iii. Land lease income that is received less frequently than monthly shall be considered income at the time it is available; and

iv. Funds in the BIA account prior to the month of application shall be counted as a resource and not as income. All deposits of land lease monies made after the application date are counted as income.

30) Insurance Award/Legal settlements, less attorneyôs fees, shall be counted as unearned income (i.e., lump sum compensation).

31) Loans. Money received from a private individual, commercial institution, or educational institution when repayment is expected and promised. A loan may be documented or may be based on a verbal agreement. A loan is differentiated from a gift or contribution because the person who made the loan expects repayment within an amount of time agreed upon.
   a. Title XIX (Medicaid) excludes loans from unearned income (See Interest and Dividends for loan repayment);
   b. Title XXI (Kids Care) counts all loans as unearned income except for certain educational loans.

32) Mortgages and Sales Contracts. Payments received from mortgages or sales contracts shall be considered unearned income for the amount of payment, which is interest.

33) Nonrecurring cash gifts that do not exceed $30 per person in any calendar quarter are excluded.

34) Prizes, awards, and lottery winnings may be earned income (food, clothing, shelter, and non-cash items are excluded from unearned income).

35) Radiation Exposure Compensation Payments are excluded.

36) Railroad Retirement benefits shall be counted as unearned income.

37) Reimbursement for work-related expenses that do not exceed the actual expense amount are excluded.

38) Relocation Payments are excluded.

39) Rental Income. Income generated solely from rental payment, and not for services provided, shall be counted as unearned income.

40) Reparation Payments to Holocaust Survivors are excluded.

41) Retirement Income, Pensions and Annuities shall be counted as unearned income.

42) Ricky Ray Hemophilia Relief Fund Act of 1998 payments are excluded.

43) Social Security Administration (SSA) Benefits.
   a. SSA Benefits (sometimes referred to as RSDI--Retirement Survivors, and Disability Insurance) are granted to eligible wage earners and/or to their dependents or survivors.
   b. SSA Educational Benefits for persons 18 to 22 years of age who are full-time students.
   c. When RSDI Benefits are paid to a representative payee on behalf of a member of the applicant/family and the payee

lives in the same household as the applicant/family, the RSDI Benefits shall be counted as income. When the representative payee does not live in the household, the RSDI Benefits shall be counted only to the extent that the payee makes them available for the support of the beneficiary.

44) Spina Bifida Payments are excluded.
45) Stocks sold shall be counted as unearned income.
46) Strike pay shall be counted as unearned income.
47) Supplemental Security Income (SSI). Payments to aged and disabled individuals whose other income is below the Federal Benefit Rate and who also meet other requirements. The SSI amount added to the amount of the other income less certain deductions equals the Federal Benefit Rate (FBR).
    a. SSI may be paid to a representative payee on behalf of the entitled person. When SSI is paid to a representative payee follow the procedure used for Social Security benefits paid to a representative payee.
    b. A child who receives SSI has Medicaid coverage and is therefore ineligible for Kids Care. When a person receiving SSI is living in a Kids Care Income Group the SSI income is counted as unearned income for Title XXI (Kids Care) and excluded for Title XIX (Medicaid).
    c. SSI designated account and interest earned on the account is excluded.
48) TANF income, which is counted as unearned income, is excluded.
49) Tax Refunds. Federal and State income tax refunds including any portion identified as Earned Income Tax Credit (EITC) shall be disregarded as income.
50) Trust Funds. All payments received by the individual/family from a trust fund shall be counted as unearned income.
51) Unemployment Insurance (UI) Benefits, which is unearned income, shall be considered to be received by an individual on the third postal workday following the date benefits are mailed.
    a. A postal workday is any day other than a Sunday or Federal holiday.
    b. The first day is the first postal work day following the mailing date.
52) Vendor payment made by an organization or person who is not a member of the family or MED unit, to a third party to cover family expenses is excluded.
53) Veteransô Administration Benefits (VA). Payments to veterans, their dependents, or survivors. Includes Retirement, Survivors, and Disability Benefits and pension adjustments for medical

expenses. VA adjustment for medical expenses may be included on the check with the pension.

a. Title XXI (Kids Care) counts all VA benefits as unearned income.
b. Title XIX (Medicaid) excludes from unearned income the portion of the pension payments, which are an adjustment for medical expenses. This adjustment includes VA Aid and Attendance. The remainder of the pension check is treated as unearned income.

54) Volunteersô Cash Compensation. Payments to volunteers in some government programs to help cover expenses they incur by volunteering. The amount must be less than the Federal Minimum wage. These programs include:
a. Volunteers in Service to America (VISTA);
b. ACTION; and
c. Older Americans Act programs.
If the volunteer cash compensation is less than the federal minimum wage, the entire amount of compensation is excluded from unearned income. If the amount of compensation is greater than or equal to the federal minimum wage, the amount is treated as wages (see Section 20.531, #15.)

55) VISTA income shall be excluded if it does not exceed the State or Federal minimum wage, whichever is greater.

56) Winnings from bingo or any other form of gambling shall be counted as unearned income.

57) WIC Payments are excluded.

3. Earned Income

Earned income is defined as either cash or in-kind income received from the receipt of wages, salaries, commissions, or profit from activities in which an individual is engaged as a self-employed person or an employee. The following list includes sources of earned income, which shall be counted in the month of receipt. The list also includes exclusions or other treatment of earned income amounts that vary depending on whether the program applied for is Title XIX or Title XXI. The following list is not all-inclusive.

1) Arizona Training Program. Salaries to handicapped persons working in a sheltered workshop situation are considered earned income.

2) Arizona Works! Program. Earnings from the Arizona Works! Sponsored on-the-job training; or Public Service Employment or from full or part-time job entries resulting out of participation in Arizona Works, except work incentive payments and

reimbursements for training related expenses, are counted as earned income.

3) Babysitting or Child Care Income. Earnings from babysitting, including DES Day Care, is counted as earned self-employment income. Any income from the Child Care Food Program is disregarded.
4) Blood and Plasma Sales. Earnings from these sales are considered earned self-employment income.
5) Can or Bottle Collections and Sales. Earnings from these sales are considered earned income.
6) Contract Income. Earnings received by individuals employed on a contractual basis (including school employees who are paid on a regular schedule for nine months on a twelve-month contract) are counted as earned income.
7) Housekeeper or Home Health Aides. Income earned as a housekeeper or home health care aide is counted as earned income.
8) In-Kind Income. The value of any item, which the individual receives in return for labor expended, is counted as earned income.
9) Job Opportunity and Basic Skills Training (JOBS). JOBS is a group of programs, including On-the-Job Training (OJT), Work Supplementation, Community Work Experience Program (CWEP), and other programs designed to help participants rejoin the workforce. Participants may receive wages for full or part-time job participation which is counted as earned income. Reimbursement for training-related expenses is excluded.
10) Job Training Partnership Act (JTPA):
    a. Income is counted as earned income for Title XXI (Kids Care).
    b. For Title XIX, the treatment of income is dependent on the studentôs status; Title XIX excludes income earned through JTPA by a student. A Job Corps participant in JTPA is always considered a student. If the JTPA participant is not a student, exclude income earned through JTPA for the first six months that the earnings are received during the calendar year. The six months do not have to be consecutive to qualify for this exclusion.
11) Jury Pay is counted as earned income.
12) Rental Income. Earned rental income includes any monies, less expenses, received from rental property when work is involved.
    a. Work may include, but is not limited to, managing rental property requiring maintenance, collection of rent, or accounting functions.
    b. If the individual does not work to maintain the property or records, rent is considered unearned income.

13) Self-Employment. Earned self-employment income includes income derived from a business enterprise such as, but not limited to, taking in roomers or boarders, ranching, farming, swap meet sales, cosmetic sales, babysitting, blood and plasma sales, janitorial services, guiding for hunting, or fishing or any wholesale or retail sales. An explanation of how to determine the applicable gross income to be used in the CRS member payment responsibility calculation follows:
    a. Gross business receipts are the total cash received from the business activity. This is the income before business expenses are deducted.
    b. Business expenses, sometimes called ñoverheadò expenses, include all expenses related to the production of goods and/or services. Allowable expenses include, but are not limited to:
        i. Costs of stocks or inventories;
        ii. Costs of operating machinery or equipment;
        iii. Rent, mortgage payments or property taxes on the business property (Note: only the interest on mortgage payments is an allowable expense; the principal is not an allowable expense);
        iv. Salaries paid to employees, as well as employer-paid benefits;
        v. Insurance; and
        vi. Advertising
    c. The following are not deductible as business expenses:
        i. Depreciation, unless declared for Federal income tax purposes;
        ii. Federal, state, or local income tax payments;
        iii. Entertainment expenses;
        iv. Personal transportation (including but not limited to transportation to and from work);
        v. Cost of purchasing capital equipment; and
        vi. Payments on the principal of loans.
        vii. Gross business receipts less business expenses equal the profit. The profit is the amount to be used in counting income.
14) Summer Youth Employment and Training Program (SYETP) Payments.
    a. Title XXI (Kids Care) counts the income as earned income; and
    b. Title XIX (Medicaid) excludes the income.
15) Work Study Program Income of College Students-Educational benefits paid to a college student.

a. For both Title XIX and Title XXI, the payments are excluded as earned income when funded by the U.S. Department of Education;
b. When the funding is from any other source, the payments are counted as wages; and
c. See Educational Benefits also.

16) Vocational Rehabilitation sponsored on-the-job training is excluded as earned income.

17) Wages. Gross earnings from employment, prior to any deductions, garnishments, allowances or adjustments, are counted as earned income. Special benefits or deductions connected with employment earnings include:
a. Advances, bonuses and commissions;
b. Reimbursements - The amount of a reimbursement from an employer for a job-related expense which is in excess of the actual expense is counted as earned income;
c. Sick pay and vacation pay; and
d. Tips. The actual amount of tips received is counted as earned income

4. Deductions from Income

A. There are certain deductions from income that are allowed when determining potential eligibility for Title XIX (Medicaid or ALTCS) and Title XXI (Kids Care) programs. These allowances include deductions for dependent care and cost of employment.

1) Dependent Care:
If the household income group received earned income and anticipates receiving earned income for the next 12 months, a deduction may be taken for the care of a child or incapacitated adult if written proof of the disability or incapacitation is provided. Both the individual receiving the earned income and the individual receiving care must live in the family household.

a. Child Care:
This is the cost paid to any babysitter or day care provider with the following requirements:

i. If the wage earner is employed on a full-time basis (86 hours or more per month), up to $200.00 per month per child less than two years of age will be deducted and up to $175.00 per month per child age two or older will be deducted.

ii. If the wage earner is employed on a part-time basis (less than 86 hours per month), up to $100.00 per month per child less than two years of age will be deducted and up to $88.00 per month per child age two or older will be deducted.

b. Incapacitated Adult Care:
This includes costs paid to a provider for the care of an incapacitated adult. ñIncapacityò is to be determined by a licensed physician or psychologist. A signed and dated statement is required.

i. If the wage earner is employed on a full-time basis (86 hours or more per month), up to $175.00 per month will be deducted.

ii. If the wage earner is employed on a part-time basis (less than 86 hours per month), up to $88.00 per month will be deducted.

2) Cost of Employment:
For any employed individual or parent whose earned income is to be included in the household adjusted gross income, $90.00 may be deducted from earnings each month for the cost of employment to compensate for job-related personal expenses such as transportation, uniforms, and mandatory payroll deductions.

B. If the medically qualified applicant or member **is in**eligible for federally funded programs such as Title XIX or Title XXI programs, they may take additional deductions from their income when determining ADHS/CRS member payment responsibility. These are additional deductions allowed by CRS that are not allowed for Title XIX or Title XXI. These deductions should be taken from income only when the applicant or member is <u>not</u> being referred to Title XIX or Title XXI programs.

1) Health insurance premiums paid by the household income group within the previous twelve (12) months.

2) Unpaid medical and dental expenses incurred by any individual in the household income group prior to the date of application or at the time of a redetermination which are the householdôs financial responsibility and not subject to any applicable third party payment.

3) Medical and dental expenses paid directly by the household income group for any household individual during the twelve (12) months prior to the date of application and not

subject to any applicable third party payment or reimbursement.

C. When an applicantôs gross annual income is at or below 200% of the Federal Poverty Level limit (FPL) amounts for income and family size, the CRS Regional Contractor shall not request additional information from the applicant to verify deductions from income.

5. Calculation of Household Adjusted Gross Annual Income

ADHS/CRS uses the adjusted gross annual income of the household income group to determine the payment responsibility for CRS services. The calculation of the adjusted gross annual income is completed in the following manner:

1) Determine the total income of the household income group. The total income includes both earned income and unearned income. The CRS Regional Contractor must use the ADHS/CRS provided ñMember Payment Responsibility Worksheetò to assist in documenting this calculation.
2) For a household whose individuals receive wages or salaries, calculate the annual wage by multiplying the frequency of pay periods in one year by the amount received in each pay period. For example, if the individual receives $500 every two weeks, the annual wage is $500 x 26 pay periods in one year for a total wage of $13,000.
3) For a household whose individuals are self-employed or seasonal workers, use the previous yearôs annual earned income as the total earned income. If the self-employed individual was not self-employed for a full year, calculate annual earned income based upon those months of income since self-employment began.
4) Determine cost of dependent care and the cost of employment deductions for the past 12 months. Refer to Section 20.603, 4., Deductions from Income.
5) The adjusted gross annual income of the household income group equals the earned income plus the unearned income minus the annual allowable deductions from income.
6) If the applicant is not potentially eligible for federally funded programs such as Title XIX or Title XXI programs, additional deductions may be taken for paid and unpaid medical expenses and health insurance premiums.
7) The adjusted gross income is compared to the member payment responsibility standards.

20.604 Member Payment Responsibility Standards

1. When the CRS Regional Contractor identifies a CRS member as having private health insurance they shall ensure collection of payment for CRS Services as defined in below and in Section 50.300 of this policy manual.
2. If a CRS member enrolled in AHCCCS with no private insurance refuses services from CRS, a letter will be sent to the member/guardian informing them that they may be financially responsible ñin accordance with AHCCCS regulations regarding billing for unauthorized Services.ò
3. Title XIX and Title XXI members with private insurance are not required to receive services from CRS.
4. The following CRS members shall not pay for CRS services:
   A. Wards of the state or court;
   B. DES adoption subsidy children;
   C. DES/CMDP foster children;
   D. AHCCCS (Title XIX and XXI) members; and
   E. State Only Members with an adjusted gross household income of less than or equal to 200% of the current Federal Poverty Level amount for income and family size.
5. State Only members with insurance who have an adjusted gross household income of greater than 200% of the current Federal Poverty Level amount for income and family size shall pay:
   A. Co-payments, excluding CRS Regional Clinic visits and Outreach Clinic visits;
   B. Deductibles according to the individualôs insurance requirements; or
   C. 100% of the following rates if the memberôs insurance denies due to out of network or non-covered services:
      1) The AHCCCS hospital per diem rates for all inpatient hospital services;
      2) The AHCCCS hospital outpatient cost to charge ratio for all hospital outpatient services; and
      3) The AHCCCS fee schedule for all physician and supplier services.
6. State Only Members Without Health Insurance

   The following categories of members without health insurance coverage shall pay as follows:

A. A member who has an adjusted gross household income of less than or equal to 200% of the current FPL limit amount for income and family size.

B. A member who has an adjusted gross household income of greater than 200% of the current FPL limit amount for income and family size 100% of the following rates:

1. The AHCCCS hospital per diem rates for all inpatient hospital services;
2. The AHCCCS hospital outpatient cost to charge ratio for all hospital outpatient services; and
3. The AHCCCS fee schedule for all physician and supplier services.

7. The CRS Regional Contractor shall ensure that a member is not denied services because of the memberôs inability to pay a co-payment or deductible.

20.605 Member Payment Agreement and/or Assignment of Benefits

1. Every non-AHCCCS applicant, or if the applicant is a minor, the parent of the non-AHCCCS applicant shall complete and sign a member payment agreement that acknowledges and accepts his/her financial responsibility;
2. Every applicant (AHCCCS and Non-AHCCCS) shall sign an agreement to assign benefits to CRS as follows:

A. Assignment of insurance benefits to ADHS/CRS and CRS providers;

B. Agreement that any monies received by the member as a court award or settlement of a claim which provides for the medical care of the member shall be used to pay CRS providers for care which is authorized and provided;

C. Agreement that when any insurance benefits, court awards, claim settlements or other third party benefits are available, they shall be exhausted before ADHS/CRS funds shall be used to provide care for the member, or shall be used to reimburse ADHS/CRS or the CRS Regional Contractor for all care provided to the member; and

D. Agreement that if the member receives and converts any benefits described by this subsection to the member's personal use and not for payment of the member's CRS services, the member shall be personally responsible for the payment of the services for which the benefits were intended to pay.

3. Signing Authority for Non AHCCCS members

    1. A parent must sign the ADHS/CRS Payment Agreement for a minor child under 18 years old. When the applicant is a married or unmarried individual over 18 years old, the parent or guardian may sign the ADHS/CRS Payment Agreement if the parent or guardian is exercising financial responsibility for the care and control of the applicant.

    2. The CRS applicant or applicantôs spouse over 18 years old may sign the ADHS/CRS Payment Agreement if the applicant or spouse is exercising the financial responsibility for the care and control of the applicant**.**

20.700 Initial Medical Evaluation

1. If a CRS Regional Medical Director or designee makes a preliminary determination that an applicant is medically eligible for CRS and the applicant seeks to enroll in CRS, the applicant shall attend a CRS clinic for an initial evaluation for medical determination.

2. If a CRS physician determines that further diagnostic testing is required before a determination of medical eligibility can be made, the CRS Regional Contractor shall:

    A. If not enrolled in Title XIX (DES) or Title XXI (Kids Care), ensure that applicant/parent understands their payment responsibilities prior to any diagnostic testing being done and that the applicant/parent signs a member payment responsibility agreement. If the applicant/parent does not sign a member payment responsibility agreement, the CRS Regional Contractor shall inform the applicant/parent that the diagnostic testing cannot be ordered and then sends a written notice of withdrawal to the applicant/parent.

    B. If the applicant has insurance, Title XIX (DES), or Title XXI (Kids Care) that covers the diagnostic testing the CRS physician shall:

        1) Request the applicant have the diagnostic testing completed through the insurance company and have the results of the diagnostic testing sent to CRS;

        2) Assist the applicant by working with the applicant's insurance company to obtain prior authorization of services, billing and collection from the third party payer and obtain the diagnostic results; and

3) Make a determination of medical eligibility after reviewing the diagnostic test results.

C. If the applicant does not have insurance that covers the required diagnostic testing or is not a Title XIX or Title XXI recipient, the CRS Regional Contractor shall:

1) Order the required diagnostic testing; and

2) Make a determination of medical eligibility after reviewing the diagnostic test results.

D. If a CRS Regional Contractor determines from the initial medical evaluation at a CRS clinic that an applicant who is Title XIX or XXI eligible is medically eligible for CRS, the CRS Regional Contractor shall consider the applicant enrolled in CRS on the day of the initial evaluation. If the applicant is not Title XIX or XXI on the day of the enrolling visit, he/she will not be eligible to receive any additional services from CRS until after the applicant complies with all enrollment requirements. Once all requirements are met, the CRS enrollment date shall correspond to the date of the medical eligibility determination.

E. If a CRS Regional Contractor determines from the initial medical evaluation at a CRS clinic that an applicant is not medically eligible for CRS, the CRS Regional Contractor shall send a written notice of denial:

1) To the applicant/parent and instruction on how to request an Administrative Hearing for denial of enrollment in CRS;

2) To the referring physician; and

3) To the ALTCS/ Acute Care Contractor when applicable.

20.800 Re-determination of Eligibility for Enrolled Members

1. At any time, the CRS Regional Contractor may request a member or, if the member is a minor, the member's parent to submit financial or non-medical information/documents for re-determination of eligibility.

2. At any time, a member or, if the member is a minor, the member's parent may request a re-determination of the member's payment responsibility by submitting to the CRS Regional Contractor a written request for re-determination.

3. The CRS Regional Contractor shall contact the member or parent within 30 days from receipt of the member or parent request to re-determine eligibility and schedule a financial interview.

4. The CRS Regional Contractor shall re-determine whether a member remains financially eligible for CRS and member's payment responsibility as follows:

   A. If the member has previously been identified as Title XIX or Title XXI , the CRS Regional Contractor shall:

      1) Verify that the member remains Title XIX or Title XXI eligible;

      2) Provide the member a notice that informs the member that he/she remains eligible for CRS and includes a new CRS expiration date; and

      3) Not require a member payment agreement.

   B. If a member is not currently Title XIX /XXI eligible, the member, or memberôs parent if the member is a minor, will need to re-apply with the appropriate agency and/or fill out a financial application along with completing an interview with the CRS Regional Contractor.

   C. If the member is classified as State Only and the net income (gross income minus allowable deductions) of the member's household group is more than 200% of the FPL, the CRS Regional Contractor shall:

      1) Notify the member or parent before 45 days of the CRS member's expiration date; and

      2) If the member or parent has maintained a net income above the 200% FPL, have the member sign and return to the CRS Regional Contractor a new Member Payment Agreement form within 30 days of the notice; or

      3) If the member or parent has not maintained a net income above the 200% FPL, ask the member to schedule a financial interview to determine the member's payment responsibility within 30 days of the notice.

      4) If the CRS Regional Contractor re-determines that a State Only member remains eligible for CRS, the CRS Regional Contractor shall provide the member with a notice that the member remains eligible for CRS and includes a new CRS expiration date.

20.900 Termination of Enrollment

1. Per A.A.C. R9-7-306, a CRS Regional Contractor shall terminate a memberôs enrollment in CRS if one of the following occurs:
   A. The CRS Regional Contractor determines that the member no longer meets the medical and/or any of the non-medical eligibility requirements for CRS;
   B. The member does not enroll in Title XIX or Title XXI federally funded program after a determination has been made by the program that the member is eligible for enrollment in the program;
   C. A member who enrolls in a Title XIX or Title XXI program does not remain enrolled in the federally funded program while eligible for the federally funded program;
   D. The member or, if the member is a minor, the memberôs parent requests a termination of CRS services/enrollment. (If the member is a TITLE XIX/XXI recipient and does not have third party insurance, the Regional Contractor shall advise the member of the financial implications of termination and refer her to her ALTCS/Acute Care Contractor);
   E. A State Only member or, if the member is a minor, the memberôs parent, fails to comply with the signed payment agreement or submission requirements, when applicable; or
   F. A State Only member or, if the member is a minor, the memberôs parent, fails to provide documentation or information requested by a CRS Regional Contractor within defined timelines; or
   G. A State Only member, or parent if the member is a minor, does not complete a re-determination before the expiration date of the memberôs CRS enrollment.
2. If a CRS Regional Contractor terminates a memberôs enrollment in CRS, the CRS Regional Contractor shall:
   A. Complete an ADHS/CRS clinic patient discharge form and place it in the individualôs CRS medical record;
   B. Update the memberôs medical record and notify ADHS/CRS of the memberôs termination via the eligibility update process;
   C. Send a written dis-enrollment letter to the member or, if the member is a child, a parent of the member, including the Hearing Rights as defined in Section 20.1100; and

D. Send a copy of the written notice of termination to the member's primary care provider, and health plan/program contractor if applicable.

20.1000 Archiving CRS Financial Enrollment Records

1. CRS members actively enrolled in CRS shall have all their financial enrollment records maintained at all the CRS Regional Sites where services are being provided.
2. CRS members who are terminated from CRS shall have their financial enrollment records maintained at the regional site for a minimum of three (3) years.
3. Regional Contractor(s) may submit terminated CRS member financial enrollment records, after three (3) years, to the State Archives.
4. CRSA shall retain the records in the State Archives in accordance with its internal policy and as required by its contract with AHCCCS.

20.1100 Applicant Eligibility Hearing Process

Applicant Rights

1. The CRS Regional Contractor shall allow an applicant the right to:
   A. A State Administrative Hearing for denial of enrollment in CRS.
   B. Copies, at the applicant's expense, of any relevant document not protected from disclosure by law.

Who May File

1. An applicant in response to an adverse action taken by a CRS Regional Contractor may request a State Administrative Hearing.
2. An authorized representative, including a provider, acting on behalf of the applicant, with the applicant's written consent, may request a State Administrative Hearing.

Time Frame for Requesting a Hearing

1. An applicant or authorized representative shall submit a written request for a State Administrative Hearing to ADHS/CRS within 30 days of receiving the Notice of Action. The request shall contain the applicant's name, the adverse action taken by a CRS Regional Contractor, and the reason for the State Administrative Hearing request.

Notice of Hearing

1. ADHS/CRS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if the request for a State Administrative Hearing is timely and contains the information listed below.
2. The Notice shall contain:

    A. A statement of time, place and nature of the hearing.
    B. A statement of the legal authority and jurisdiction under which the hearing is to be held.
    C. A reference to the statutes and rules involved.
    D. A short plain statement as to the matters in question.
    E. The scheduled date for the hearing may be advanced or delayed n a showing of good cause or on agreement by the parties involved.

Notice of Hearing Decision

1. ADHS/CRS shall mail a Decision to the applicant, member, or authorized representative no later than 30 days after the date of the Administrative Law Judgeôs recommended decision.

Denial of a Request for a State Administrative Hearing

1. ADHS/CRS shall deny a request for a State Administrative Hearing upon written determination if:

    A. The request for a State Administrative Hearing is untimely;
    B. The request for a State Administrative Hearing is not for an adverse action permitted under this policy;
    C. The request for a State Administrative Hearing is moot based on the factual circumstances of the case; or
    D. The sole issue presented is a federal or state law requiring an automatic change adversely affecting some or all applicants.

Withdrawal of a Request for a State Administrative Hearing

1. ADHS/CRS shall accept a written request for withdrawal from the applicant, member, or authorized representative if a Notice of Hearing has not been mailed.
2. If ADHS/CRS has mailed a Notice of Hearing, AHCCCS or ADHS/CRS shall forward the written request for withdrawal to the Office of Administrative Hearings (OAH).

Motion for Rehearing or Review

1. Under A.R.S. § 41-1092.09, ADHS (for non-Title XIX and non-Title XXI members) or AHCCCS (for Title XIX and Title XXI members) shall grant

a rehearing or review for any of the following reasons materially affecting an applicant's or member's rights:

A. Irregularity in the proceedings of a State Administrative Hearing that deprived a petitioner of a fair hearing;
B. Misconduct of ADHS, AHCCCS, OAH, or a party;
C. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
D. The decision is the result of passion or prejudice;
E. The decision is not justified by the evidence or is contrary to law; or
F. Good cause is established for the nonappearance of a party at the hearing.

20.1200 No-Show

20.1201 No-Show Applicant Appointments

If an applicant fails to attend an initial medical evaluation appointment, the CRS Regional Contractor shall follow these steps:

A. Contact the applicant/family by phone or letter to reschedule the appointment. If the applicant/family does not respond after two attempts to contact (with at least 48 hours between attempts), a letter must be sent to the applicant/family indicating that their CRS application will not be processed if the initial medical evaluation appointment is not rescheduled.
B. For a second missed appointment, follow the steps in A. above. For applicants who are AHCCCS members, the AHCCCS Health Plan/Program Contractor must be notified of the applicant's no-shows for two scheduled initial medical evaluation appointments.
C. For a third missed appointment, the applicant/family and the AHCCCS Health Plan/Program Contractor, if applicable, must be notified by letter of the termination of the application and the methods by which to re-apply.
D. CRS must document all attempts to contact the applicant/family.
E. If after any attempts made to contact the applicant there is no response within thirty (30) days, the CRS Regional Contractor shall notify the applicant/family and the AHCCCS Health Plan/Program Contractor of the termination of the application and the methods by which to re-apply.

20.1202 No-Show Member Appointments

If a member fails to attend an appointment, the CRS Regional Contractor shall follow these steps:

A. Per Section 20.900, Termination of Enrollment, the CRS Regional Contractor cannot terminate a member for no-show appointments.

B. Contact the member/family by phone or letter to reschedule the appointment. If the member/family does not respond after two attempts to contact (with at least 48 hours between attempts), a letter must be sent to the member/family requesting to reschedule the appointment.

C. For a second missed appointment, follow the steps in B. above. For applicants who are AHCCCS members, the AHCCCS Health Plan/Program Contractor must be notified of the member's no-shows for two scheduled appointments.

D. For a third missed appointment, the member/family and the AHCCCS Health Plan/Program Contractor, if applicable, must be notified by letter that the member/family needs to contact the CRS clinic to reschedule the appointment or contact the CRS clinic to receive services.

E. If after any attempts to contact the member/family there is no response within thirty (30) days, the CRS Regional Contractor shall provide notice to the member/family and the AHCCCS Health Plan/Program Contractor that the member/family needs to contact the CRS clinic to reschedule an appointment.

F. If CRS eligible members, who have no primary insurance or Medicare, refuse to receive CRS covered services through the CRS program, the CRS Regional Contractor must send written notification to the member informing them that the member may be responsible to pay for those services received outside of the CRS program. The non-CRS provider may bill the member in accordance with AHCCCS regulations regarding billing for unauthorized services.

G. CRS must document all attempts to contact the member/family.

Attachment A

Children's Rehabilitative Services (CRS)
Referral Application Process
Turn Around Document (TAD)

Number of Pages including Cover: _____

Date sent to DES: _____ **CRS Patient Name:** _____

To DES Contact:	**From CRS Contact:**	**To CRS Contact:**
FAX Number ***(Include Area Code)*****:**	**FAX Number** ***(Include Area Code)*****:**	**FAX Number** ***(Include Area Code)*****:**
Phone No ***(Include Area Code)*****:**	**Phone No** ***(Include Area Code)*****:**	**Phone No** ***(Include Area Code)*****:**

Verification Documents	**List the document used for verification**
Residence	
Identity	
Citizenship	
Alien Status (when applicable)	
Social Security Number	
Dependent Care Expense	
Income	
Include Copy of Application	Date of Application:

To Be Completed by DES and Returned to Children's Rehabilitative Services	
Case Name:	Case Number:

Date TAD/Documents Received at DES:	Effective Date of Eligibility:	Application Denied ï Reason:	
Date Notice Sent to Applicant:	Eligôs Name:	Phone No:	Site Code:

Completion Instruction for
Children's Rehabilitative Services (CRS) Referral Process
Turn Around Document (TAD)

A. Purpose. This form will enable the CRS provider and Department of Economic Security (DES) staff to transmit information for the Medical Assistance eligibility process. It will also enable the provider to identify the information used to verify the factors of eligibility being sent to DES. This form will also provide a means for DES staff to send the Medical Assistance determination information to the provider.

B. Completion. All items are self-explanatory except the following:

1. The provider completes the top portion.

2. The DES local office completes the portions marked **To Be Completed By DES and Returned to Children's Rehabilitative Services**.

   Complete a systems check to determine whether the applicant has an ACTIVE, INACTIVE, or PENDING case.

   If the case is **DENIED**, enter the specific reason for denial. The reason code is **not** acceptable.

C. Routing. FAX to the DES local office.

D. Retention. Retain in accordance with the providerôs and DESôpolicies and procedures.

Table of Contents - Chapter 30.000
Covered and Excluded Conditions

30.000 COVERED AND EXCLUDED CONDITIONS

30.100 Preface

CRS enrolls individuals who have specific medically handicapping or potentially handicapping conditions. This chapter defines the conditions that are covered and excluded by the CRS Program. CRS conditions are set forth in A.A.C. Title 9, Chapter 7, Article 2, Section 201.

30.200 General Philosophy

The philosophy of the CRS Program is based upon an individual's need for treatment of CRS conditions through medical, surgical, or therapy modalities where the following three criteria are present:

1. Specialized treatment is necessary;
2. Functional improvement is potentially achievable; and
3. Long-term follow-up may be required for maximum achievable results.

30.300 CRS Covered Conditions and Excluded Conditions

A CRS covered condition is a condition or disease that qualifies for treatment in the CRS program if other requirements are met. An excluded condition is not covered by CRS. The following section lists covered conditions and variations of the condition or related conditions that are excluded from coverage.

30.301 Cardiovascular System Conditions

1. Cardiovascular system conditions covered by CRS include the following:
   - A. Congenital heart defects
   - B. Cardiomyopathies,
   - C. Valvular disorders,
   - D. Arrhythmias,
   - E. Conduction defects,
   - F. Rheumatic heart disease that is not in the acute stage,
   - G. Renal vascular hypertension, catecholamine hypertension,
   - H. Arteriovenous fistulas, or
   - I. Kawasaki Disease with evidence of coronary artery aneurysm.
2. The following cardiovascular conditions are excluded:
   - A. Essential hypertension,
   - B. Premature atrial, nodal, or ventricular contractions of no hemodynamic significance,

C. Arteriovenous fistulas which may be a problem cosmetically, but do not cause cardiac failure or threaten loss of function, or

D. Functional murmurs of no physiological significance, including peripheral pulmonic stenosis.

30.302 Endocrine System Conditions

1. Endocrine system conditions covered by CRS include the following:
   - A. Hypothyroidism,
   - B. Hyperthyroidism,
   - C. Adrenogenital syndromes,
   - D. Addison's Disease,
   - E. Hypoparathyroidism,
   - F. Hyperparathyroidism,
   - G. Diabetes Insipidus,
   - H. Panhypopituitarism (defined as laboratory confirmation of a deficiency of growth hormone and two other pituitary hormones. After confirmation, members are eligible to receive growth hormones. Members without other resources who were enrolled in CRS prior to November 1, 1995 with a less stringent definition of panhypopituitarism will continue treatment under a grandfather clause), or
   - I. Cystic Fibrosis.
2. The following endocrine system conditions are excluded:
   - A. Diabetes mellitus (includes treatment of diabetes mellitus in a member with cystic fibrosis),
   - B. Isolated Growth Hormone Deficiency (Patients with panhypopituitarism, will receive growth hormone),
   - C. Hypopituitarism encountered in the acute treatment of malignancies, and
   - D. Precocious puberty.

30.303 Genitourinary System Conditions

1. Genitourinary system conditions covered by CRS include the following:
   - A. Vesicoureteral reflux, with at least mild or moderate dilatation and tortuosity of the ureter and mild or moderate dilatation of renal pelvis,
   - B. Ectopic ureter,
   - C. Ambiguous genitalia,
   - D. Ureteral stricture,
   - E. Complex hypospadias,
   - F. Hydronephrosis,
   - G. Deformity and dysfunction of the genitourinary system secondary to trauma. Once the acute phase of the trauma has

passed, CRS covers the corrective component of the deformity or dysfunction (see Section 30.407),

H. Pyelonephritis which has failed medical management and requires surgical intervention,
I. Multicystic Dysplastic Kidneys,
J. Nephritis associated with lupus erythematosis, or
K. Hydrocele associated with ventriculo-peritoneal shunt.

2. The following genitourinary conditions are excluded:
   A. Nephritis, infectious or noninfectious, except when associated with lupus erythematosis,
   B. Nephrosis (nephrotic syndrome),
   C. Undescended testicle,
   D. Phimosis,
   E. Hydrocele, unless the hydrocele is associated with a ventriculo-peritoneal (VP) shunt,
   F. Enuresis, unless the enuresis is secondary to a CRS condition,
   G. Meatal Stenosis, or
   H. Simple hypospadias, defined as isolated glanular or coronal aberrant location of the urethral meatus without curvature of the penis.

30.304 Ear, Nose, and Throat Conditions

1. Ear, nose and throat conditions covered by CRS include the following:
   A. Cholesteatoma,
   B. Chronic mastoiditis,
   C. Deformity and dysfunction of the ear, nose, or throat secondary to trauma. Once the acute phase of the trauma has passed, CRS covers the corrective component of the deformity or dysfunction,
   D. Neurosensory hearing loss,
   E. Congenital malformations,
   F. Significant conductive hearing loss (greater than or equal to 30 decibels), one sided or bilateral, which despite medical treatment requires a hearing augmentation device (example: ossicular dysfunction),
   G. Otitis media in a child with cleft lip and palate or neurosensory hearing loss,
   H. Craniofacial anomalies that require multi-specialty, interdisciplinary treatments; and
   I. Microtia that requires multiple surgical interventions.
2. The following ear, nose, and throat conditions are excluded:
   A. Tonsillitis,
   B. Adenoiditis,

C. Hypertrophic lingual frenum,
D. Nasal polyps, except for members with cystic fibrosis,
E. Cranial or Temporal Mandibular Joint Syndrome, simple deviated nasal septum,
F. Recurrent otitis media without cleft lip and palate or without neurosensory hearing loss,
G. Obstructive apnea,
H. Acute perforations of the tympanic membrane,
I. Sinusitis, except for members with cystic fibrosis,
J. Isolated preauricular tags and/or pits, or
K. Drooling and/or excessive salivation.

30.305 Musculoskeletal System Conditions

1. Musculoskeletal system conditions covered by CRS include the following:
   A. Osteochondrodysplasias, including:
      1) Achondroplasia,
      2) Hypochondroplasia,
      3) Diastrophic dysplasia,
      4) Chondrodysplasia,
      5) Chondroectodermal dysplasias,
      6) Spondyloepiphyseal dysplasia and variants,
      7) Metaphyseal and epiphyseal dysplasias,
      8) Larsen Syndrome,
      9) Fibrous dysplasia,
      10) Osteogenesis imperfecta,
      11) Rickets (all variants),
      12) Enchondromatosis, multiple cartilaginous, exostoses, single exostosis with evidence of functional impairment or rapid enlargement, or
      13) Other osteochondrodysplasia as determined by CRS Regional Medical Director review.
   B. Juvenile rheumatoid arthritis and seronegative spondyloarthropathies,
   C. Orthopedic complications of hemophilia,
   D. Neuromuscular conditions, including:
      1) Myopathies,
      2) Muscular dystrophies,
      3) Myoneural disorders,
      4) Arthrogryposis,
      5) Spinal muscle atrophy, or
      6) Polyneuropathies, including Guillain Barré after the acute stage.

E. Bone and joint infections (chronic stage),
F. Upper limb malformations:
   1) Amputations, and
   2) Syndactyly.
G. Spinal deformity, including:
   1) Kyphosis,
   2) Scoliosis, or
   3) Congenital spinal deformity with functional loss.
H. Cervical spine abnormalities, congenital and developmental,
I. Lower limb malformation,
   1) Hip dysplasia,
   2) Slipped capital femoral epiphysis,
   3) Femoral anteversion and tibial torsion that is:
      i. For an individual under eight years of age, associated with a neuromuscular disorder that is a CRS condition; or
      ii. For an individual eight years of age or older, causing significant functional impairment, as determined by CRS;
   4) Legg-Calve-Perthes Disease,
   5) Amputations, including prosthetic sequelae of cancer,
   6) Metatarsus adductus,
   7) Leg length discrepancy of 5 centimeters or more,
   8) Metatarsus primus varus,
   9) Dorsal bunions, and
   10) Complex bunions.
J. Collagen vascular diseases,
K. Benign bone tumors,
L. Deformity and dysfunction secondary to musculoskeletal trauma in a patient 15 years of age and younger at the time of initial injury, where the deformity and dysfunction is not in the acute phase (example: of three months duration. See Section 30.407). Once the acute phase of the trauma has passed, CRS covers the corrective component of the deformity or dysfunction,
M. Osgood Schlatter's disease that has failed medical management, or
N. Complicated flat foot, defined as a rigid foot, unstable subtalar joint or significant calcaneus deformity.

2. The following musculoskeletal conditions are excluded:
   A. Ingrown toenails, unless secondary to a CRS condition,
   B. Back pain with no structural abnormalities,
   C. Ganglion cysts,

D. Uncomplicated flat foot,
E. Fractures except in cases where the fracture is caused by the CRS condition, and treatment is part of the CRS condition,
F. Popliteal cysts,
G. Femoral anteversion and tibial torsion, unless
   1) Associated with a neuromuscular disorder when the individual is under 8 years of age; or
   2) The individual is 8 years of age or older and has significant functional impairment,
H. Simple bunions, unless secondary to the CRS condition, or
I. Carpal Tunnel Syndrome, unless secondary to the CRS condition.

30.306 Gastrointestinal System Conditions

1. Gastrointestinal system conditions covered by CRS include the following:
   A. Tracheoesophageal fistula,
   B. Anorectal atresia,
   C. Hirschsprungs Disease,
   D. Diaphragmatic hernia,
   E. Gastroesophageal reflux which has failed medical management and requires surgical intervention,
   F. Deformity and dysfunction of the gastrointestinal system secondary to trauma. Once the acute phase of the trauma has passed, CRS covers the corrective component of the deformity or dysfunction (See Section 30.407),
   G. Biliary atresia,
   H. Congenital atresia, stenosis, fistuli, or rotational abnormalities of the gastrointestinal tract,
   I. Cleft lip and cleft palate (either or both conditions may be present),
   J. Other congenital malformations of the gastrointestinal tract:
      1) Omphalocele, or
      2) Gastroschisis.
2. The following gastrointestinal conditions are excluded:
   A. Malabsorption Syndrome (Short Bowel Syndrome), except for members with cystic fibrosis,
   B. Crohn's Disease,
   C. Hernias except for diaphragmatic hernia,
   D. Ulcer disease,
   E. Ulcerative colitis,
   F. Intestinal polyps,
   G. Pyloric Stenosis, or

H. Celiac Disease.

30.307 Nervous System Conditions

1. Nervous system conditions covered by CRS include the following:
   - A. Uncontrolled seizure disorders, where there have been more than two seizures with documented adequate blood levels of one or more medications,
   - B. Simple or controlled seizure disorders are covered when the child has no other health insurance. AHCCCS/KidsCare/private insurance eligible individuals will be treated through those provider networks,
   - C. Cerebral Palsy,
   - D. Muscular dystrophies or other myopathies,
   - E. Myoneural disorders,
   - F. Neuropathies (hereditary and idiopathic),
   - G. Central nervous system degenerative diseases,
   - H. Central nervous system malformations and structural abnormalities,
   - I. Hydrocephalus,
   - J. Craniosynostosis in a child less than 18 months of age of sagittal sutures, or unilateral coronal sutures, or multiple sutures,
   - K. Myasthenia gravis, congenital, or acquired,
   - L. Benign intracranial tumor,
   - M. Benign intraspinal tumor,
   - N. Tourette's Syndrome,
   - O. Residual dysfunction after resolution of an acute phase of vascular accident, inflammatory condition, or infection of the central nervous system,
   - P. Myelomeningocele (Spina Bifida),
   - Q. Neurofibromatosis,
   - R. Deformity and dysfunction secondary to trauma in a patient 15 years of age and under at the time of the initial injury. Once the acute phase of the trauma has passed (acute phase includes acute rehabilitation), CRS covers the corrective component of the deformity or dysfunction (See Section 30.407),
   - S. Sequelae of near drowning, after the acute phase, or
   - T. Sequelae of spinal cord injury, after the acute phase.
2. The following nervous system conditions are excluded:
   - A. Headaches,
   - B. Suspected seizure disorder,
   - C. Central apnea secondary to prematurity,
   - D. Near Sudden Infant Death Syndrome,

E. Febrile seizures,
F. Occipital plagiocephaly, either positional or secondary to lambdoidal synostosis,
G. Trigonocephaly secondary to isolated metopic synostosis,
H. Spina bifida occulta,
I. Near drowning in the acute phase, or
J. Spinal cord injury in the acute phase.

30.308 Ophthalmologic Conditions

1. Ophthalmological conditions covered by CRS include the following:
   A. Cataracts,
   B. Glaucoma,
   C. Disorders of the optic nerve,
   D. Non-malignant enucleation and post-enucleation reconstruction,
   E. Retinopathy of prematurity,
   F. Disorders of the iris, ciliary bodies, retina, lens, or cornea, or
   G. Simple refractive error and astigmatism for the above conditions.
2. The following ophthalmologic conditions are excluded:
   A. Simple refraction error, except for members with an eligible ophthalmologic condition,
   B. Astigmatism, except for members with an eligible ophthalmologic condition,
   C. Strabismus (with the exception of children with cerebral palsy, myelomeningocele, shunts and specific CRS eligible ophthalmologic disorders), or
   D. Ptosis.

30.309 Respiratory System Conditions

1. Respiratory system conditions covered by CRS include the following:
   A. Anomalies of the larynx, trachea, and bronchi that require surgery,
   B. Nonmalignant obstructive lesions of the larynx, trachea and bronchi.
2. The following respiratory system conditions are excluded:
   A. Respiratory distress syndrome,
   B. Asthma,
   C. Allergies,
   D. Bronchopulmonary dysplasia,
   E. Emphysema,
   F. Chronic Obstructive Pulmonary Disease, or
   G. Acute or chronic respiratory care for the neuromuscularly impaired.

30.310 Integumentary System Conditions

1. Integumentary system conditions covered by CRS include the following:
   A. Craniofacial anomalies that require multispecialty interdisciplinary treatment,
   B. Burn scars where the burn scar is functionally limiting,
   C. Complicated nevi requiring staged procedures,
   D. Hemangioma where the hemangioma is functionally limiting, and
   E. Cystic hygroma.
2. The following integumentary conditions are excluded:
   A. Deformities without limitations to activities of daily living,
   B. Simple nevi,
   C. Skin tags,
   D. Port wine stain,
   E. Craniofacial anomalies with cosmetic considerations only,
   F. Sebaceous cysts,
   G. Isolated malocclusions (without documented functional loss),
   H. Pilonidal cysts, or
   I. Ectodermal dysplasia.

30.311 Genetic and Metabolic Conditions

1. Genetic and metabolic conditions covered by CRS include the following:
   A. Amino acid and organic acidopathies,
   B. Inborn errors of metabolism,
   C. Storage diseases,
2. Metabolic conditions ascertained through the Arizona Newborn Screening Program:
   A. Phenylketonuria,
   B. Galactosemia,
   C. Homocystinuria,
   D. Hypothyroidism,
   E. Maple syrup urine disease,
   F. Biotinidase deficiency, or
   G. If the Arizona Newborn Screening Program adds other metabolic conditions to the screening panel, the CRS Program will apply for additional funding through the legislative budget process to cover the treatment of the added conditions.

30.312 Hematologic Conditions

1. Hematologic system conditions covered by CRS include the following:
   A. Sickle cell anemia and other hemoglobinopathies,
   B. Pre and postoperative iron deficiency anemia incurred as a result

of a CRS condition.

30.313 A Medical Condition, Other Than One of the Conditions Listed Above, as Determined by a CRS Regional Contractor Medical Director

1. Requires specialized treatment similar to the type and quantity of treatment a covered medical condition in sections 30.301 through 30.312 requires,
2. Is as likely to result in functional improvement with treatment as a covered medical condition in sections 30.301 through 30.312, and
3. Requires long-term follow-up of the type and quantity required for a covered medical condition listed in sections 30.301 through 30.312.

30.400 Other Excluded Conditions or Services

Sections 30.401 through 30.413 specify other conditions or services excluded from coverage in the CRS Program.

30.401 Allergies

Allergies are excluded.

30.402 Anorexia and Obesity

Eating disorders, including anorexia, bulemia, and obesity, are excluded.

30.403 Autism

Autism is excluded.

30.404 Burns

Burns are excluded. However, a burn scar that limits function or movement may be a CRS condition (see Integumentary System Conditions, Section 30.310).

30.405 Cancer/Oncology

Cancer/oncology is excluded.

30.406 Chronic Vegetative State or Profound Mental Retardation

A chronic vegetative state or profound mental retardation is excluded as a primary diagnosis. These conditions are characterized by little or no interaction with the environment and little or no likelihood of functional improvement.

30.407 Deformity and Dysfunction Secondary to Trauma or Injury

Coverage of deformity and dysfunction secondary to trauma or injury is limited to children who are 15 years of age and under at the time of the initial injury. The deformity or dysfunction must have passed the acute phase (at least 3 months must have passed since the injury or trauma incident).

30.408 Dental and Orthodontia Services

1. Dental services are excluded, except for treatment of CRS members with the following conditions:
   A. Cleft lip or cleft palate,
   B. Documented significant functional malocclusion,
   C. Cardiac conditions where the member is at risk for subacute bacterial endocarditis,
   D. Cerebral spinal fluid diversion shunt where the CRS member is at risk for subacute bacterial endocarditis, or
   E. Dental complications arising as a result of treatment for a CRS condition.
2. Orthodontia services are excluded, except for treatment of CRS members with the following conditions:
   A. Cleft palate, or
   B. Documented significant functional malocclusion.

30.409 Depression or Other Mental Illness

Depression or other mental illness is excluded unless the depression or other mental illness is secondary to a CRS condition. If the depression or other mental illness is related to a CRS condition, a therapeutic trial of medication is allowed. Individuals should be referred to an appropriate agency for ongoing treatment.

30.410 Developmental Delay

Developmental delay is excluded.

30.411 Dyslexia/Learning Disabilities

Dyslexia and other learning disabilities, educational handicaps, minimal cerebral dysfunction, and behavioral problems are excluded.

30.412 Failure to Thrive

Failure to thrive is excluded.

30.413 Hyperactivity

Hyperactivity, including Attention Deficit Disorder, is excluded.

30.414 Ilizarov for Leg Lengthening

Ilizarov for leg lengthening is excluded, except when there is a presence of, or predicted, leg length discrepancy of greater than, or equal to five (5) centimeters at skeletal maturity.

30.415 Immunodeficiency

Immunodeficiency is excluded. Immunodeficiency includes conditions such as:

1. HIV (Human Immunodeficiency Virus)
2. AIDS (Acquired Immune Deficiency Syndrome)

Table of Contents - Chapter 40.000
CRS Services

Table of Contents - Chapter 40.000
CRS Services (Con't)

40.000 CRS Services

40.100 Preface

The Arizona Children's Rehabilitative Services (CRS) Program provides for medical treatment, rehabilitation, and related support services to qualified individuals who have certain medical, handicapping, or potentially handicapping conditions as defined in A.A.C. R9-7-202.
CRS accepts eligible applicants who require treatment for medical conditions that are conducive to treatment in clinic-based multi-specialty/interdisciplinary settings or in designated centers of excellence where specialized treatment is necessary, functional improvement is potentially achievable, and long-term follow-up may be required for maximum achievable results. Chapter 30.000 outlines CRS covered and excluded conditions. CRS provides services to enrolled members who meet the qualifications of the program. Chapter 20.000, Enrollment Requirements, outlines other requirements.
CRS provides services through regional service contracts where the approach to service delivery is family-centered, coordinated, culturally competent, and considers the unique medical holistic needs of eligible persons. The policies included in this chapter delineate the provisions for rendering CRS services.

40.200 Scope of Services

The CRS Program provides covered medical, surgical, or therapy modalities for enrolled members. The CRS Program provides specialty services for CRS eligible conditions. Other health insurance plans, third party payors, or the individual pay for routine, preventative, or acute medical care needs.

40.201 CRS Contractors Providing Non-Covered Services

Service restrictions, exclusions, or prior authorization requirements do not apply if a CRS Regional Contractor elects to provide non-covered services. Costs associated with providing non-covered services shall not be included in costs used to develop contractor reimbursement rates. A CRS Regional Contractor shall use other funds to cover any costs of providing non-covered services.

40.202 CRS Service Requirements

CRS services must be medically necessary and:
1. Related to the CRS condition,
2. Provided in a multi-specialty, interdisciplinary setting where appropriate,
3. Provided to enrolled members, and
4. Rendered in accordance with rules, contractual requirements, and prior authorization requirements.

40.300 CRS Medical Services

This section provides detailed information on the types of services provided by the CRS Program to treat CRS conditions. Included are any restrictions and exclusions for the services. Certain services may be available only in limited types of service settings or may be medically appropriate only for certain age groups or for individuals with a particular clinical presentation. Services may require prior authorization from the CRS Regional Contractors and may require additional documentation to justify the medical necessity of the service for treating the CRS condition. Unless otherwise specified, coverage limits for services are per event.

40.301 Audiology Services

1. Covered Services:
   CRS provides covered audiology services to CRS members who are hearing impaired or whose CRS condition poses a risk for hearing impairment. Audiology services include:
   A. Audiologic Assessments
      1) Audiologic assessments shall be consistent with accepted standards of audiologic practice.
      2) CRS may provide Brainstem Audiology Evoked Response (BAER) evaluations at the request of the CRS physician.
   B. Hearing Aid Fittings and Evaluations
      1) Hearing aids are provided for CRS members. The member may have the hearing aid reevaluated annually at the CRS clinic.
      2) A hearing aid may be replaced once every three years, unless the member experiences a change in hearing levels or is determined by a CRS contracted audiologist to require a hearing aid replacement.
      3) Replacement of lost hearing aids is limited to one replacement per 12-month period.
      4) Implantable bone conduction devices are covered for members with prior authorization from the CRS Regional

Medical Director or designee.

5) Tactile hearing aids are covered for CRS members with prior authorization from the CRS Regional Medical Director or designee. Each application for CRS coverage of a tactile hearing aid shall be submitted by the CRS contracted audiologist.

2. Exclusions and limitations:
   A. Cochlear implants are excluded. CRS does not pay for:
      1) Cochlear implants,
      2) Testing that is specific to preparation for cochlear implants, or
      3) Post operative interventions that are specific only to cochlear implants.
   B. Accessory items are excluded. Only items necessary for proper functioning and maintenance of the hearing aid are included.

40.302 Dental and Orthodontia Services

1. Covered Services
   A. Dental Services
      CRS provides a full range of dental services only to enrolled members who have one of the following diagnosed conditions or circumstances:
      1) Cleft lip and/or cleft palate,
      2) A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis,
      3) A cardiac condition where the member is at risk for subacute bacterial endocarditis,
      4) Dental complications arising as a result of treatment for a CRS condition, or
      5) Documented significant functional malocclusion where malocclusion is defined as functionally impairing in a member with a craniofacial anomaly (e.g., hemifacial microsomia, Treacher Collins Syndrome) or when one of the following criteria is present:
         Masticatory and swallowing abnormalities affect the nutritional status of the individual resulting in growth abnormalities,
         a) The malocclusion induces clinically significant respiratory problems such as dynamic or static airway obstruction, or
         b) Serious verbal communication disturbance as determined by a CRS contracted speech therapist. Report must indicate the malocclusion as the

primary etiology for the speech impairment and that speech cannot be further improved by the speech therapy alone.

6) Orthodontia Services

7) Orthodontia services are covered for a member with a diagnosis of cleft palate or documented significant functional malocclusion.

2. Exclusions and Limitations

A. Dental and orthodontia services may be provided in CRS clinics. When services are limited or in communities where there is no CRS clinic; the dental and orthodontia services may be provided at the CRS practitioner's private office.

B. All dental and orthodontic treatment plans require written prior authorization from the CRS Regional Contractor if the services are provided outside the CRS clinic.

40.303 Diagnostic Testing and Laboratory Services

1. Covered Services

CRS Regional Contractors shall provide member access to the following laboratory and diagnostic testing services:

A. A full service laboratory including blood bank, pulmonary function, micro processing, testing with STAT capability, including phlebotomy and blood specimen preparation services, as well as equipment for performing CBCs and urinalysis.

B. A full service general radiographic unit in or adjacent to the outpatient clinic.

C. Special diagnostic testing services including: visual evoked response, CT scan, ultrasound, brainstem auditory evoked response (BAER), magnetic resonance imaging (MRI), electroencephalogram (EEG), electrocardiogram (EKG), and echocardiogram.

2. Exclusions and Limitations

A. Diagnostic Testing

Diagnostic testing is a covered service when specifically used to test for additional CRS conditions or to make treatment-planning decisions.

B. Laboratory Services

Follow-up laboratory evaluations where discovered laboratory abnormalities are unrelated to the CRS condition are excluded. The individual must be referred to his or her primary care physician for follow-up care.

For example, an applicant is found to have sickle cell anemia, a CRS condition, but is also human immunodeficiency virus (HIV)

positive. Follow-up care for the HIV status must be referred to the individual's primary care physician.

40.304 Durable Medical Equipment

1. Covered Services
   - A. Medically necessary durable medical equipment is provided to the member for the purpose of rehabilitative care that is directly related to treatment for a CRS condition.
   - B. Equipment repairs are covered when medically necessary.
   - C. CRS covers equipment modifications that are medically necessary.
   - D. Oxygen therapy for up to 30 calendar days shall be covered when ordered by a CRS physician for the treatment of a CRS condition.
2. Exclusions and Limitations
   - A. Members are eligible for equipment only when they are being followed in a medical or surgical CRS clinic. All equipment shall be directly related to the care of the CRS condition.
   - B. Equipment is covered only when an authorized CRS provider orders it.
   - C. Coverage is excluded for equipment used only for school purposes.
   - D. Oxygen and related supplies are limited to 30 calendar days of coverage. Requests for extension may be submitted to the CRS Regional Contractor's Medical Director or designee.
   - E. Coverage is excluded for the following items:
     1) Cranial modeling bands, except for members who are 24 months of age or younger who have undergone CRS approved cranial modeling surgery and demonstrate postoperative progressive loss of surgically achieved correction and that without intervention would most likely require additional remodeling surgery,
     2) Mobilizer walker,
     3) Motorized caster carts,
     4) Motorized vehicles,
     5) Motorized wheelchairs,
     6) Standers,
     7) Strollers, except when used as modified seating for positioning, and
     8) Toileting aids.
3. Equipment Maintenance

   CRS does pay for equipment modifications necessary due to the member's growth or due to changes in the member's orthopedic or health needs. The CRS physician, the physical therapist, or occupational therapist shall recommend equipment modifications.

   CRS does not pay for repairs needed because of improper use or neglect.

4. Equipment replacement
   A replacement for lost or stolen equipment shall be requested in writing to the CRS Regional Medical Director or his/her designee. If the equipment was stolen, a copy of the police report, verifying the incident, must be submitted to the appropriate CRS clinic.
5. Wheelchairs and Ambulation Devices
   A. Covered Services
      1) CRS will provide and modify wheelchairs for CRS members, as well as provide ambulation assistive devices (crutches, canes, walkers).
      2) CRS covers medically necessary equipment modifications due to member's growth or changes in the member's orthopedic or health needs.
      3) Wheelchairs and ambulation devices are covered when:
         a) There is a change in the member's medical condition,
         b) The equipment is no longer safe to operate, or
         c) The child has outgrown the equipment.
      4) Custom fit standers and parapodiums with click-clacks are covered for braced-walking potential for spinal cord defect patients.
      5) Trays for wheelchairs will be provided when documentation indicates that the need is directly related to improvement in functional skill level.
   B. Exclusions and Limitations
      1) CRS does not provide any power wheelchair or adaptive power switches for wheelchairs.
      2) CRS will not supply a member with a second non-power wheelchair or ambulation device if the member already has a wheelchair or ambulation device that is in good working order.
      3) Replacement of wheelchairs and ambulation devices is not a covered service when the equipment is functional and can be repaired such that the equipment is safe to operate.
      4) CRS does not pay for physical or structural modifications to a home.
      5) The CRS member's family or guardian shall be responsible for the care of and transportation of equipment.
      6) The CRS member and/or his or her family shall demonstrate that they can safely use all equipment provided to the member. Practical and functional use of equipment shall be documented in the member's CRS medical record.
      7) Wheelchairs and ambulation devices used solely for school purposes are excluded.

8) CRS may repair or provide maintenance of equipment that, although not provided to the member by CRS, a CRS provider has determined to be safe and appropriate.
9) Wheelchair and ambulation device needs shall be met through recycled items, i.e., wheelchairs, if the item meets needed specifications.
10) Short-term rental wheelchairs and ambulation devices are limited to 30 calendar days. The CRS Regional Medical Director or designee may approve requests for extension.

40.305 Home Health Care Services

Home health care services include professional nurse visits, therapies, social work services, equipment, and medications.

1. Post-hospitalization
   Home health care services are limited to the post-hospitalization rehabilitative or recovery period or are provided in lieu of hospitalization, not to exceed 30 calendar days per event. Services must be ordered by the CRS Provider. Home health care services may be extended if it is determined to be medically necessary, upon the approval of the CRS Regional Medical Director or designee.
   B. Home health care services provided in a memberôs place of residence includes:
      1) Assessment of home health needs,
      2) IV therapies,
      3) Wound evaluation,
      4) Administration of medications,
      5) Monitoring vital signs,
      6) Monitoring oxygen administration,
      7) Monitoring and assessing patient physical signs,
      8) Teaching and evaluating of therapies,
      9) Enterstomal therapy and teaching,
      10) Catheter insertion, care, and teaching, and
      11) Instruction regarding home health care to member or memberôs caregivers.
2. Exclusions and limitations
   Home health care services are limited to the post-hospitalization rehabilitative or recovery period or are provided in lieu of hospitalization, not to exceed 30 calendar days per event.
   Requests for extension must be submitted to the CRS Regional Medical Director or designee.
   Home health care services must be ordered by the physician who is supervising the CRS care for the member.

40.306 Inpatient Services

CRS covers inpatient acute care hospitalization only for a CRS member at the CRS contracted provider sites. The hospitalization is covered for a member when the hospitalization is specifically for the treatment of a CRS condition.

1. Requirements for Admission and CRS Reimbursement for an Inpatient Acute Care Stay
   - A. Only CRS physicians can admit and treat CRS members for CRS conditions. Physicians must have a contract with a CRS Regional Contractor or be appropriately credentialed with a CRS Regional Contractor to admit and treat CRS members.
   - B. The admitting physician shall obtain prior authorization from the CRS Regional Contractor for all non-emergency hospital CRS related admissions.
   - C. Prior authorization is not required for an emergency admission that is related to a CRS condition.
   - D. The primary reason for hospitalization shall be related to the CRS condition.
   - E. CRS does not provide hospitalization for the sole purpose of maintaining the member, i.e., long-term ventilatory support, nutritional support.
   - F. See Chapter 80.000 for Discharge Planning and Transfers.
2. Rule Out Ventricular Infection or Rule Out Ventricular Shunt Failure CRS will pay for the initial diagnostic evaluation by a CRS provider to rule out a ventricular infection or ventricular shunt failure at a CRS contractor hospital. The period of time covered for the rule out is from the time of admission until the results of the CT scan, MRI, CFS culture, or measurements of ICP are available to the physician. If the member does not have a shunt infection or failure as described above, he or she must be decertified from CRS payor liability from the point of the neurosurgeonôs diagnosis forward. The responsibility for hospitalization for the acute illness is transferred to the appropriate payor. CRS Regional Contractorôs utilization review staff coordinates the transition of care with other payors and related agencies.

40.307 Growth Hormone Therapy

CRS covers growth hormone therapy for members with panhypopituitarism. See Section 30.302 of the RCPPM.

40.308 Nursing Services

Nursing services include:

1. Direct nursing care to members during specialty clinics and supervision of

subordinate nursing staff during specialty clinics;

2. Documented nursing care assessments, interventions, implementation, and revisions of care following evaluation;
3. Education of members, families, caregivers, and other staff in treatment and testing procedures, health promotion, self-care skills, and anticipatory guidance; and
4. Discharge planning and care coordination services.

40.309 Nutrition Services

1. Covered Services
   Nutrition services include screening, assessment, intervention, and monitoring. CRS Regional Contractors shall cover nutrition services for CRS members with special nutritional needs when the nutritional need is related to a CRS condition.
2. Exclusions and Limitations
   A. A registered dietitian must provide nutrition services.
   B. CRS does not cover total parenteral nutrition (TPN) for long-term nutrition. TPN services may be provided for a member in lieu of hospitalization for preparation of an authorized CRS surgery, for a period not to exceed 30 calendar days.
   C. CRS covers nutritional supplements upon referral from CRS physicians with consultation by a registered dietician in accordance with the following guidelines:
      1) Metabolic Disorders
         Formulas for metabolic disorders such as PKU, MSUD, HCU, and isovaleric acidemia that are treated by a special diet are covered based on the CRS Regional Contractorôs formulary or CRS Regional Medical Director approval and in accordance with the following guidelines:
         a) PRODUCTS: Specified formulas for treatment of metabolic disorders such as Lofenalac, Phenyl-Free, Analog X, Maxamaid X, MSUD Diet Powder, and formula component products such as Mead Johnson Product 80056.
         b) QUANTITY: As needed, based upon demands for growth and maintenance, to be determined by the registered dietitian.
         c) DURATION: As long as treatment through dietary modification continues, up to 21 years of age.
         d) NOT COVERED: Lactose-free formulas for galactosemia; infant formulas or milk products used in con-junction with modified amino acid formulas; low protein food products such as pasta, breads, and

cookies for amino acid disorders.

2) Tube Feedings
Tube feedings and medically necessary tube feeding equipment are available for CRS members when the need is related to a CRS condition.
   a) PRODUCTS: Commercially available tube feeding formulas such as Compleat, Isocal, Osmolite, and formula component products such as Polycose.
   b) QUANTITY: As needed, based upon demands for growth and maintenance, to be determined by the physician or registered dietitian.
   c) DURATION: Limited to 30 calendar days of coverage. The CRS Regional Medical Director or designee must approve extension for cover-age.
   d) EQUIPMENT: Tube feeding equipment, such as feeding pumps, will be provided by CRS when deemed medically necessary to provide adequate nutrition.
   e) NOT COVERED: Foods and beverages recommended for blenderized recipes.

3) Cystic Fibrosis
Nutrition services are available for CRS members with cystic fibrosis when appropriate growth and maintenance requires a supplemental product and no other resources or community nutrition support programs are available.
   a) PRODUCTS: Commercially available nutrition supplements for additional calories and other nutrients. Examples include Ensure, Enrich, Sustacal, and formula component products such as MCT oil. (Consult manufacturers' product handbooks for nutritional content.)
   b) QUANTITY: Limited to approximately 50 percent of daily caloric needs for infants, individuals, and adults as a supplement to a regular diet unless the cystic fibrosis individual is also being tube fed (see 2 above).
   c) DURATION: Limited to 30 calendar days of coverage. The CRS Regional Medical Director or designee must approve extension for cover-age.
   d) NOT COVERED: Foods and beverages that constitute the memberôs regular diet.

40.310 Outpatient Services

1. Covered Services

Covered outpatient services include:

A. Ambulatory surgery,
B. Outpatient diagnostic services,
C. Ancillary services,
D. Emergency room services, and
E. Clinic Services.

1) Multi-specialty, interdisciplinary Clinics

CRS members may require multi-specialty, interdisciplinary teams of care. The CRS Program and CRS Regional Contractors develop and provide the availability of these teams throughout the state to the greatest extent possible, within the limits of appropriated funds.

Members cannot enter the program directly into a specialty clinic without an assessment and evaluation from the CRS Regional Medical Director or designee who is authorized to determine medical eligibility.

The CRS Regional Medical Director shall authorize all specialty clinics.

CRS specialty clinics may include but are not limited to:

a) Amputee,
b) Arthritis/rheumatology,
c) Cardiac,
d) Cystic fibrosis,
e) ENT,
f) Endocrine,
g) Eye,
h) Genetics,
i) Hand,
j) Myelomeningocele,
k) Neurofibromatosis,
l) Neurology,
m) Neurosurgery,
n) Nutrition,
o) Orthodontia,
p) Orthopedics
q) Cerebral palsy,
r) Plastic surgery,
s) Pulmonary,
t) Rhizotomy,
u) Scoliosis,

v) Sickle cell anemia,
w) Urology,
x) General surgery,
y) Feeding,
z) Wheelchair, and
aa) Metabolic.

2) Community-Based Outreach Clinics
   a) CRSA develops outreach clinics where the demand exists and resources are available. Community-based outreach clinics are specialty clinics that are held periodically in locations other than the CRS Regional Contractorsô normal clinic locations such as in outlying towns and communities in Arizona, or on Indian Reservations.
   b) Outreach clinics may include:
      i. Cardiac,
      ii. Orthopedic,
      iii. Genetic,
      iv. Neurology,
      v. Plastic Surgery, and
      vi. Ear, Nose, and Throat (ENT).

2. Limitations
   The memberôs primary health care system must be used for routine and acute medical care that is not related to the CRS condition, such as periodic visits for scheduled immunizations and periodic physical examinations and check-ups.

40.311 Pharmaceuticals

1. Covered Services:
   Pharmaceuticals are covered when appropriate to the treatment of the CRS condition when ordered by the CRS physician and when provided through a contracted pharmacy.
   Covered services also include special formulation nutrition needs for metabolic patients. See Section 40.309, Nutrition Services.
2. Exclusions and Limitations
   A. Pharmaceuticals or supplies that would normally be ordered by the primary care physician for the overall health maintenance of the individual are not covered (i.e., multiple vitamins).
   B. Cerezyme for the treatment of Gaucherôs Disease covered by catastrophic reinsurance under Arizona Health Care Cost Containment System (AHCCCS) for Title XIX and Title XXI members is not covered by CRS.
3. CRS Regional Contractors are required to provide a pharmacy location

either in the CRS Regional Contractorôs clinic area or as approved by CRS.

4. CRSA shall maintain a statewide formulary that may be changed through change submissions to the CRSA Medical Director.
5. Exceptions to the formulary may be made under special circumstances when approved by a Contractorôs Medical Director following the contractorôs policy and procedure.

40.312 Physical and Occupational Therapy Services

Physical and occupational therapy services must be related to the memberôs CRS condition.

1. Covered services:
   - A. Before a scheduled surgery,
   - B. After a surgery,
   - C. After removal of a cast,
   - D. If a medication is used to treat a CRS memberôs neurological or orthopedic function,
   - E. After the member receives an orthotic or prosthetic device,
   - F. After a hospitalization, and
   - G. If the member:
     1) Is unable to obtain physical therapy or occupational therapy through a source other than CRS, and
     2) Has a strong potential for rehabilitation as determined by a CRS provider.
2. Limitations
   CRS shall provide no more than 24 sessions of physical therapy or 24 sessions of occupational therapy for each occurrence described in covered services.

40.313 Physician Services

Physician services shall be furnished by a licensed physician and shall be covered for members when rendered within the physicianôs scope of practice under A.R.S Title 32. A physician shall be a member of a CRS contracted facilityôs professional staff and shall be appropriately credentialed. CRS Regional Contractors are responsible for contracting with physician specialists with expertise in pediatrics to provide CRS services.

Medically necessary physician services may be provided in an inpatient or outpatient setting, and shall include:

1. Medical evaluations, consultation, and diagnostic workups,
2. Medically necessary treatment for the CRS condition,
3. Prescriptions for medications, supplies and equipment,
4. Referrals to other specialists or health care professionals when necessary, and

5. Patient education.

40.314 Prosthetic and Orthotic Devices

1. Covered Services
   A. Prosthetic and orthotic devices are provided to a member for treatment of a CRS condition.
   B. CRS covers prosthetic and orthotic modifications or repairs which are medically necessary because of the individualôs growth or due to changes in the individualôs orthopedic or health needs or when equipment is no longer safe.
   C. CRS covers ocular prostheses and replacements when related to a CRS condition. CRS also provides and replaces ocular prostheses for CRS members when medically necessary.
   D. A replacement for lost or stolen prosthetic and orthotic devices shall be requested in writing to the CRS Regional Medical Director or designee. If the device was stolen, a copy of the police report, verifying the incident, must be submitted to the appropriate CRS clinic.
2. Exclusions and Limitations
   A. Myoelectric protheses are excluded.
   B. Shoes are excluded.

40.315 Psychology and Psychiatry Services

1. Psychology Services
   A. Covered Services
      1) Covered psychology services include short-term crisis intervention, assessment, evaluation, and referral to other services.
      2) A state licensed psychologist must provide psychology services.
   B. Exclusions and Limitations
      1) Psychology services for CRS members and their families require a referral from the CRS physician or professional staff.
      2) Psychology services are limited to three (3) visits per calendar year, and must be related to the memberôs CRS condition. Additional psychology visits may be covered when approved by the CRS Regional Medical Director or designee. CRS does not provide ongoing psychological counseling or services.
2. Psychiatry Services
   A. Covered Services

CRS provides psychiatry services to CRS members upon evaluation and referral by a CRS psychologist.

B. Exclusions and Limitations
   1) Psychiatry services are limited to one (1) visit per calendar year, and must be related to the member's CRS condition.
   2) Additional visits may be covered when approved by the CRS Regional Medical Director or designee.

40.316 Second Opinions and Diagnostic Referrals

1. Covered Services
   CRS covers second opinions by other CRS contracted physicians.
2. Exclusions and Limitations
   A. Only one-second opinion is allowed out of the home site region per episode or specialty.
   B. Second opinion visits will be provided at the first available appointment.
   C. Office visits for second opinions may be arranged on an urgent basis at the discretion of the home site contractor.
3. Responsibilities
   A. The home site (referring) CRS Regional Contractor shall generate the referral.
   B. The home site CRS Regional Contractor shall send a second opinion referral request and appropriate medical records to the referral site.
   C. The home site CRS Regional Contractor shall verify the member's enrollment in CRS prior to completing the Transfer Request form.
   D. The referral site shall send a copy of the visit report to the home site.
   E. Each CRS Regional Contractor shall be responsible for developing its own internal procedures for processing second opinion requests.
   F. There will be no charge to the home site CRS Regional Contractor by the referral site CRS Regional Contractor for clinic-based services.
   G. Diagnostic services provided outside the home site's region (when such services are available within the region) and visits to out-of-region physicians' offices are the fiscal responsibility of the home site CRS Regional Contractor and must be preauthorized by the home site.
   H. Diagnostic services, which are not available within the home site's region, will be the financial responsibility of the receiving site.

40.317 Speech Therapy Services

Speech therapy services must be related to the memberôs CRS condition.

1. Covered services:
   - A. Before a scheduled surgery,
   - B. After a surgery,
   - C. If a medication is used to treat a CRS memberôs neurological function,
   - D. After a hospitalization, and
   - E. If the member is unable to obtain speech/language pathology services through a source other than CRS.
2. Limitations
   CRS shall provide no more than 24 sessions of speech/language pathology services for each occurrence described in covered services.

40.318 Transplants

1. Covered services
   CRS covers transplant services for corneal transplants and incidental bone grafting transplants.
2. Exclusions and Limitations
   Organ and bone marrow transplants are excluded.

40.319 Vision Services

1. Covered Services
   Vision services include examinations, eyeglasses, and contact lenses for the treatment of a CRS condition.
2. Exclusions and Limitations
   Replacements for broken or lost glasses or contact lenses are limited to one replacement per prescription per calendar year.
   Lens enhancements such as ultra violet (UV) tinting and safety glass shall be provided as medically necessary and ordered by a CRS physician.

40.400 CRS Service Settings

CRS Regional Contractors or authorized subcontractors provide CRS services in both inpatient and outpatient settings, such as contracted hospitals, CRS Regional Clinics, and community based outreach clinics.

40.500 Family Support Services

40.501 Advocacy services

1. CRS provides advocacy services for CRS applicants, members, and families. Advocates assist applicants, members, and families to understand and access medical organizational systems community and public resources, and assists in the resolution or prevention of problems regarding CRS services. An advocate may act as a liaison between clinic staff, educators, physicians, therapists, nurses, nutritionists, other professionals, family members, and the child to prevent or resolve problems. Advocacy services include:
   A. Assisting members and their families in interpreting and understanding information so that members and their families can make informed decisions about the memberôs care,
   B. Educational resources and support for the member and family,
   C. Education of families about advocacy so that they will be empowered to act as their own advocate,
   D. Education of health care professionals in principles of family-centered care,
   E. Education of families regarding member rights and responsibilities related to the CRS program,
   F. Orientation of new members and their families, and
   G. Liaison between CRS clinic physicians, families, inpatient and outpatient staff, administrators, educators, and other professionals to prevent or resolve problems.
2. CRS Regional Contractors may provide a patient advocate in the CRS Regional Clinic to act as a liaison for families and CRS staff to resolve or prevent problems.

40.502 Care Coordination Services

1. Care coordination services include:
   A. Coordination of CRS health care through multi-specialty, interdisciplinary approach to care,
   B. Collaboration with external providers, including community agencies, service systems, other payor sources, members, and their families, i.e., referrals and program information (see Chapter 80.000 for details).

40.503 Child Life Services

CRS provides child life services. Child life services include organization of

individual, family, or group activities designed to reduce the memberôs and familyôs fear of the nature of the illness, medical care, and procedures. CRS Regional Contractors may provide structured child life activities for hospitalized CRS members either in a playroom or at the bedside and in the outpatient clinic waiting room and/or play areas for individuals and siblings.

1. Child Life activities may include:
   - A. Group activities of expressive play,
   - B. Pre-operative teaching and medical play designed to decrease fears while increasing understanding and confidence,
   - C. Explanations comprehensible to the child of sequence, nature, and reasons for procedures and routines, and
   - D. Support and coping strategies for the child during painful procedures.

40.504 Education Services

1. CRS provides education services including:
   - A. Education of and assistance to members and their families with barriers created by the CRS condition. Provide information about care, services, support systems, and advocacy.
   - B. Education of members and their families about the history and prognosis of the CRS condition, treatment options even if the medical services are not covered by CRS, treatment planning, health risks, growth and development, transition planning, and offering of genetic counseling, when appropriate, regarding the condition.
   - C. Coordination with the schools, physicians, parents, and clinic staff regarding accommodation of a memberôs special educational needs.
   - D. Coordination with the educational system regarding the educational needs of CRS members for the purpose of establishing educational needs and goals for an inpatient stay and homebound program.
   - E. Public education of community groups and organizations, public health personnel, school personnel, health care providers, insurers, regional and national health organizations, and welfare services about the CRS program and its services.
   - F. Encouragement of teaching and research initiatives.
   - G. Education to physicians, health care professionals, and other individuals regarding the unique needs and concerns related to the care and treatment of children with special health care needs.

40.505 Family Centered Care

1. CRS provides family-centered care in all aspects of its service delivery system. The responsibilities of the CRS Regional Contractors in support of family-centered care include:
   A. Recognizing the family as the primary source of support for the membersô health care decision-making process. Service systems and personnel are available to support the familyôs role.
   B. Facilitating collaboration among families, health care providers, and policymakers at all levels for the:
      1) Care of the member,
      2) Development, implementation, and evaluation of programs, and
      3) Policy development.
   C. Promoting complete exchange of unbiased information between families and health care professionals in a supportive manner at all times.
   D. Incorporating recognition of cultural diversity and individuality within and across all families, considering racial, ethnic, geographic, social, spiritual, and economic diversity.
   E. Implementing practices and policies that support the needs of families, including medical, developmental, educational, emotional, environmental, and financial needs.
   F. Administering a cultural competence self-assessment to all staff annually and provide results to CRSA.
   G. Participating in CRSA Cultural Competency training modules.
   H. Facilitating family-to-family support and networking.
   I. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.
   J. Appreciating and recognizing the unique nature of each family.

40.506 Individual and Family Rights and Responsibilities

1. Access to Care
   A. The member and family can expect impartial access to information, treatment, and accommodations that are available or medically indicated, regardless of race, color, creed, ethnicity, sex, age, religion, national origin, ancestry, marital status, sexual preference, genetic information, physical or mental handicap, diagnosis, prognosis, or sources of payment for care.
   B. The member and family can expect services that are provided in a culturally competent manner with consideration for members with limited English proficiency or reading skills and those with diverse

cultural and ethnic backgrounds, visual and/or auditory limitations.

C. The member and family can request to be seen in a CRS Clinic or by another physician.
D. The member and family can request a second opinion.
E. Members and families can be informed of medical alternatives and other types of care and how to access that care.
F. Members and families can expect to be informed in writing of changes to services.
G. Members and families can ask and be informed about how CRS pays providers and CRS bills.
H. Members and families can request results of the CRS member Satisfaction Survey.

2. Respect, Dignity, and Emotional Support
The member and family have the right to receive considerate, respectful care with recognition of personal dignity and impartial access to emotional and spiritual support at all times and under all circumstances regardless of race, ethnicity, sex, national origin, diagnosis, prognosis, or sources of payment for care.

3. Privacy and Confidentiality
A. The member and family have a right to expect every consideration of adequate personal and informational privacy.
B. CRS Regional Contractors must implement procedures to ensure the confidentiality of health and medical records and of other member information. Procedures need to:
1) Be in compliance with all federal, state, and local requirements; and
2) Include process for monitoring and ensuring compliance.

4. Identity
A. Members have the right to know the identity of physicians, nurses, and others involved in their care. This includes students, residents, or other trainees providing care to CRS members.

5. Communication
A. The member and family have a right to obtain from health care providers complete and current information about diagnosis, treatment, and expectations for outcome.
B. The member and family have a right to formulate advance directives. Advance directives must be:
1) In compliance with federal and state statutes and
2) Be documented in writing.
C. Individuals, parents, and legal guardians shall have the right to access their own medical record in accordance with the record release policy specified in Section 70.000.
D. CRS Regional Contractors shall make every effort to ensure that all information prepared for distribution to members is written at a

4th grade level. Regardless of the format chosen, the CRS recipient information must be printed in a type, style and size that can be easily read by recipients with varying degrees of visual impairment. Members must be notified that alternative formats are available and how to access them.

E. Receive translation/signer services free of charge and know about providers who speak languages other than English and how to get a free directory of CRS providers.

F. All informational materials shall be reviewed for accuracy and approved by CRSA prior to distribution to recipients.

6. Growth and Development

A. The member has the right to developmentally appropriate care with respect to the manner in which personnel speak and interact with them, choices of activities, and inclusion in decisions made about their care.

7. Grievance and Appeal Procedure

A. The member and family have the right to voice dissatisfaction they have with the treatment or care the member receives and be free from any form of punishment restraint or seclusion for decisions and filing a complaint.

B. Applicants, members, ex-members, parents, and legal representatives will be provided with information regarding how to voice complaints, file grievances, or appeals and request administrative hearings.

C. Applicants, members, ex-members, parents, and legal representatives will be provided with information regarding expedited reviews.

D. Members, parents, and legal representatives will be provided with information regarding continuation of reduced or denied services within 30 days of enrollment or changes to the information. (See Chapter 60.000 for Grievance/Appeal process).

40.507 Medical Home

CRS supports the concepts of medical home as defined by the American Academy of Pediatrics. Medical Home concepts ensure that each member has a Primary Care Provider (PCP) and that the memberôs PCP is part of the interdisciplinary approach to care and the decision-making process.

40.508 Parent Action Council – Regional

Each regional CRS clinic shall have a Parent Action Council (PAC). The PAC is a parent-driven group and participation is determined by parentôs level of interest in organizing meetings/activities. Each CRS Regional Clinic will actively

participate and support PAC activities.

1. Functions:
   Each PAC shall:
   A. Function as an active body to CRSA, CRS Regional Contractors, professionals, and physicians involved in the program. The PAC shall participate in the development of policy and procedures that influence the delivery of services to children and families that use the CRS program.
   B. Develop an annual budget and budget committee to achieve its purposes, as determined by the membership, with monies allocated from CRSA and monies collected by other means.
   C. Select two parent representatives to the State Parent Action Council (SPAC).
   D. Meet for a stated activity/meeting at least quarterly or more often as determined by the members of the PAC.
   E. Provide PAC parent representation in CRS administrative meetings, activities, and projects that influence the service delivery to children with special health care needs and their families.
   F. Ensure CRS Regional Contractor administrator or designee attendance at their regional PAC meetings.
   G. Provide interpretation services at the meetings. Provide translated written materials as needed by members of the PAC.
   H. Schedule meetings/activities and provide timely notification to potential attendees.
2. Membership:
   A. The PAC shall consist of individuals, defined as family members, foster parents, or legal guardians of a child who is, or has been a CRS patient, or adults who are or were patients, professionals, advocacy groups, the CRS Regional Contractor, and CRSA staff.
   B. The majority of voting members of each PAC membership shall consist of individuals defined as family members, foster parents, or legal guardians of a child who is, or has been a CRS patient, or adults who are or were patients.
   C. A Budget Committee shall consist of equitable representation from PAC parents and CRS Regional Contractor clinic representatives. The Budget Committee shall adhere to the expenditure guidelines of the Parent Involvement Fund Policy.

40.509 Parent Involvement PAC/Social Service Fund Policy

The CRS Parent Involvement Policy encompasses two funds, the PAC, and Social Service. The Parent Involvement-Parent Action Council (PAC) Fund supports and promotes parent involvement within the CRS Program. The Social Service Fund provides assistance with various needs of families related to assistance with

transportation and motel expense in order to attend clinic appointments and emergency expenses such as utility assistance, rent, clothing, etc. The funds will be allocated annually at the beginning of the fiscal year. To receive reimbursement, expenditures made by CRS Regional Contractors must be documented and invoices submitted to CRSA monthly or quarterly.

1. Parent Involvement/PAC Fund expenditure guidelines are as follows:
   - A. Reimbursement to parents for participation in CRS Clinic meetings, activities, and projects that influence service delivery to members and their families.
   - B. Reimbursement to parents for participation in PAC activities such as:
     1) Newsletter production,
     2) Promotion of PAC,
     3) Community liaison activities, and
     4) PAC/Regional Contractor committees, projects and activities.
   - C. Reimbursement for PAC operating expenses, approved by the PAC representation, such as:
     1) Mail-outs of PAC meeting notices, minutes, or newsletters;
     2) Costs of office supplies/services supporting PAC activities, paper envelopes, printing, duplicating costs, computer programs, and other technological supplies;
     3) Costs related to flyers, meeting notices, newsletter production; and
     4) Not more than 20% of the PAC funds may be used for operating expenses. (If parent involvement is reimbursable though the regional contractor or other sources more than 20% of these funds may be used for operating expenses/supplies.)
   - D. Per State policy, no food or beverage reimbursement is allowed.
   - E. A PAC budget committee established at each CRS Regional Contractor facility must approve PAC expenditures.
2. Guidelines for expenditure of the Social Services Fund are as follows:
   - A. Assisting families with various expenses related to their essential basic needs and to enable their attendance at the CRS clinic appointments such as, but not limited to:
     1. Transportation,
     2. Gas Vouchers,
     3. Lodging,
     4. Meals,
     5. Clothes/Shoes,
     6. Diapers/Pull Up Pants,
     7. Medication,
     8. Special Formula/Food Supplements,

9. Feeding Equipment,
10. DME Loan Chest/Repairs,
11. Adaptive Car Seats/Belting System,
12. Utilities,
13. Rent,
14. Home Health Needs,
15. Hearing Aid Insurance, and
16. Other.

B. Funds obtained from sources other than the state, i.e., community social service agencies, insurance, donations, etc., should be utilized first in covering authorized social service expenditures.

C. It is recommended that this fund be administered through the social services area of the CRS Clinics.

40.510 Pediatric to Adult Transition Services

CRS Regional Contractors shall provide Pediatric to Adult Transition Services to:

1. Enhance the smooth transition of care when a member leaves the CRS program.
2. Transition Services include:
   A. Initiating a transition plan by age fourteen (14) which is ongoing until the member exits from the CRS program,
   B. Assuring coordination with an adult primary care physician prior to memberôs exit from the CRS program,
   C. Ensuring that families, member, and their primary care providers are part of the development and implementation of the transition plan, and
   D. Documenting the transition plan in the medical record.

40.511 Social Work Services

Social work services include: information and referral, support and counseling, screening and assessment, and documentation and coordination of services.

A. CRS Regional Contractors shall provide social work services for all CRS members and their families during the memberôs hospitalization, including coordination of the memberôs hospital discharge plan.

B. CRS Regional Contractors shall provide social work services in the outpatient clinic for CRS members and families.

C. CRS Regional Contractors may provide at least one social worker to attend specified multi-specialty, interdisciplinary clinics.

40.512 State Parent Action Council (SPAC)

1. The CRS Statewide Parent Action Council is established consisting of the

following members:

A. Two parents are appointed by each of the four regional Parent Action Councils. These members shall elect two members who are appointed to Co-Chair the Statewide Council.
B. One representative from an advocacy group who is appointed by the Co-Chairs of the Statewide Council.
C. One staff member from each CRS Regional Contractor who is appointed by the CRS Regional Contractorôs Administrator.
D. One representative from CRSA who is appointed by the ADHS/OCSHCN/CRSA Office Chief.
E. Members of the SPAC shall serve terms of one to three years, method for term commencement shall be determined by the members.
F. Officers shall serve one to three year terms and method for the members shall determine term commencement.
G. The SPAC shall elect the following officers, a chairperson, treasurer, co-chairperson(s), a secretary, and may include any other officers at the discretion of the SPAC.

2. Members appointed pursuant to 40.509.1, paragraph B, C, and D of the above section are non-voting members and are not counted for the purpose of determining the presence of a quorum.
3. The State Parent Action Council (SPAC) shall:
   A. Participate in any process that changes the laws, rules, policies, or procedures that influence the delivery of CRS services to children and families.
   B. Participate in any process regarding the planning and delivery of CRS services.
   C. Promote parent involvement in treatment planning, advocacy, and member care.
   D. Participate with CRSA in the ongoing definition of parent-member rights and responsibilities.
   E. Require one parent council member from each CRS Regional Contractor to participate in the Administratorôs meetings between CRSA and the CRS Regional Contractors.
   F. Require one parent council member from each CRS Regional Contractor to participate in the Medical Director/Administratorôs meetings between CRSA and the CRS Regional Contractors.
   G. Participate in the development and distribution of the Parent Involvement/PAC Fund.
   H. Meet bi-annually at a minimum or more often as determined by the membership. Members shall determine meeting places and times.
4. The Co-Chairs shall annually meet with the CRSA Medical Director to exchange ideas regarding the delivery of services to children and families.
5. A Regional Parent Action Council is established at each of the CRS

Regional Contractor sites.

6. Council members are not eligible to receive compensation, but are eligible for reimbursement of expenses.

40.513 Translation and Interpreter Services

CRS Regional Contractors shall provide free translation and interpreter services to ensure that all CRS members and their families understand the member's diagnosis and course of recommended treatment in a culturally sensitive manner.

1. All vital materials shall be translated when CRS Regional Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of its members who also have Limited English Proficiency (LEP) in that language. Vital materials must include, at a minimum, notices of actions, member handbooks, and consent forms.
2. All written notices informing members of their right to interpretation and translation services in a language shall be translated when a CRS Regional Contractor is aware that 1,000 or 5% (whichever is less) of its members speak that language and have LEP.
3. All materials shall be translated when a CRS Regional Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of its members who have LEP in that language.
4. Every effort shall be made to ensure that all material prepared for distribution is written at the fourth grade level.
5. Written material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, have limited reading proficiency, or require sign language.
6. Individuals providing interpreter services to members/families must have an awareness and sensitivity to the culture and socio-economic background of the population in CRS and shall be fluent in the required language and understand medical terminology. Posted signage advising members of the availability, at no cost, of interpreter services is required.
7. Regional Contractors shall document in the member's medical records the member's preferred language during the enrollment/intake process. When interpretative services are provided they are to be documented in the member's medical chart.
8. CRS Regional Contractors shall ensure staff/volunteers attend education sessions and maintain agenda and sign-in sheets of education on:
   A. Awareness and sensitivity to culture
   B. Socioeconomic conditions of the CRS population
9. CRS Regional Contractors must ensure staff/volunteers providing translation/interpreter services are effective in assisting the family in participating, planning and decision making for medical care.

40.700 Services Provided Outside the State of Arizona

Services provided outside the state of Arizona are covered for CRS members when all of the following are verified:

1. The out-of-state services are related to a CRS condition,
2. The medical specialty, treatment, or procedure is not available in Arizona,
3. Two CRS physicians of the appropriate medical specialty recommend out-of-state treatment,
4. The treatment is considered to be lifesaving and will result in significant functional improvement based on favorable data published in peer reviewed national medical literature,
5. Prior authorization is obtained from the CRS Regional Medical Director and Administrator,
6. The procedures for obtaining out-of-state services are as follows:
   - A. The memberôs sub-specialist in the specialty for which the out-of-state service is needed must initiate the out-of-state service request which must include the following:
     1) The specific treatment requested,
     2) Documentation of the fact that the requested procedure is not available in Arizona and that the treatment is lifesaving or will result in significant functional improvement for the member, and
     3) The names of specific physicians and hospitals that have the necessary expertise to perform the procedure and must provide documentation of such expertise along with correspondence indicating the providersô willingness to perform the procedure for the member.
   - B. The memberôs sub-specialist requesting physician shall send the treatment request to the appropriate CRS Regional Medical Director.
     1) The appropriate region to send an out-of-state treatment request is the CRS Contractor where the requested type of treatment would ordinarily take place for the member under current CRS policy. This site is responsible for coordination of arrangements for out-of-state care and paying for that care.
     2) Before approving or denying a request, the CRS Regional Medical Director must request a consultation from a sub-specialist in the same specialty area as the requesting physician, but from another CRS Contractor, to review the request.
     3) The CRS Regional Medical Director has the authority and responsibility to approve or deny the request based on:
        a) Memberôs eligibility status.

b) Whether or not requested procedure is a covered service.
c) Adequacy of documentation submitted with the request.

C. If the CRS Regional Medical Director denies the request, he/she must notify the requesting physician of the denial and must include the grievance process (See Chapter 80.000).

D. If the CRS Regional Medical Director approves the request, he/she forwards the request to the CRS Regional Administrator.
1) The CRS Regional Administrator is responsible for negotiating the arrangements and payment rates with the out-of-state providers.
2) A member shall comply with the payment responsibility provisions of Chapter 50.000 and A.A.C. R9-7-207 for covered services received from out-of-state providers.
3) Travel expenses and lodging are not covered.
4) The out-of-state treatment site must provide a discharge summary for the member.
5) Upon receipt of the required documentation, the CRS Regional Administrator will authorize payment to the out-of-state providers.

E. The Regional Medical Director is responsible for:
1) Care coordination with the out-of state provider
2) Follow-up care for the member upon return to Arizona.

40.800 Telehealth

The purpose of Telehealth is to serve families by providing clinical and therapeutic services by means of Telehealth technology. This technology is used to deliver care services directly to the member and for the enhancement of communication, network development, and educational opportunities for members, memberôs families, CRS Regional Contractor staff, and providers. Telehealth services may include the following:

1. Regional outreach clinics,
2. Physician consultation,
3. Other professional consultation,
4. Family and professional education, and
5. Videoconferences and meetings.

40.900 Transfers and Transportation

The following sections describe the policies that relate to transferring care of a CRS member from one Regional Contractor to another and to transporting CRS members within the CRS system.

40.901 Transfer of Care

The CRS Regional Contractors shall coordinate the care for members.

1. Hospital Transfers
   A CRS hospital transfer shall be covered for a member only if all of the following conditions are met:
   A. The transfer occurs between CRS contracted facilities,
   B. The transfer is for treatment of a CRS condition, and
   C. The transfer is prior authorized by the CRS Regional Medical Director.
2. Home site transfers
   A. CRS assigns each member to a home site (a CRS Regional Contractor) based on the zip code of the memberôs residence. It is recognized that services outside the home site may be necessary for various reasons. The following outlines the criteria for partial and total transfers of care to other CRS Regional Contractors. It also delineates the CRS Regional Contractor's responsibilities for ensuring successful transfers:
      1) Criteria
         a) The home site contractor shall make every effort to meet a member's needs at its own site.
         b) When tertiary or other specialized care needed by a member is not available in the memberôs home region, the member is transferred to a region that can provide the care.
         c) Transfers of care may occur even when services are available at the home site, for the following reasons:
            i. Member or parent choice,
            ii. Extenuating circumstances such as special family situations and transportation issues,
            iii. A permanent change of residence to another CRS Regional Contractorôs zip code, or
            iv. Placement in a residential school outside the member's home region.
         d) A total transfer of care, defined as a transfer of 100% of services to another CRS Regional Contractor shall occur only when a decision is made that the member is not likely to require any care from the original CRS Regional Contractor in the future.
         e) A partial transfer of care, defined as a transfer of less than 100% of the care, shall occur when services are being provided at two or more sites

(CRS Regional Contractors) on an ongoing basis. A partial transfer is also performed when all existing services are transferred to another site but there remains a potential for services to be provided by the home site at a future date.

2) Responsibilities
   a) The home site shall generate the transfer request and shall send medical and payment responsibility documentation to the receiving/requested CRS Regional Contractor explaining the reason for the transfer.
   b) Each CRS Regional Contractor shall establish procedures for processing requests for transfer. Such procedures must ensure that members are transferred only after a thorough review of the circumstances has been performed. The procedures should include family and physician conferences when necessary.
   c) The transferring site shall be responsible for providing documentation to the parent and family.
   d) Total transfers:
      i. In the case of a total transfer, all medical records shall be transferred to the new home site by the initial home site.
      ii. A CRS financial file at the referral site should be developed for total transfers. The home site shall send a copy of the most recent CRS Financial application, CRS Payment Agreement, any insurance information, and signed Arizona Affidavit of Residency to the receiving site.
      iii. Updated member files shall be sent to the CRSA Data System Coordinator.
   e) Partial transfers:
      i. In the case of a partial transfer, all appropriate medical records and payment responsibility information shall accompany the patient to the accepting site. The home site shall be responsible for providing the records.
      ii. In a partial transfer, the member shall be registered at both sites.
   f) The home site shall generate a transfer of care explaining the reason for the transfer and all other

pertinent information.

g) The receiving site must acknowledge acceptance of the member or identify the reason for non-acceptance.

h) Subject to availability, home care, equipment, therapy, and other follow-up shall be the responsibility of the home site when a transfer is completed in a timely and appropriate manner.

3) CRSA shall adjudicate disputes regarding transfer of care among CRS Regional Contractors when the parties are unable to resolve the dispute.

40.902 Transportation Services

Transportation services are provided between CRS-contracted hospitals or facilities and must be prior authorized by the CRS Regional Medical Director or designee. Transportation to clinic appointments is excluded. Medically necessary non-emergency transportation for an AHCCCS/KidsCare member must be coordinated with the memberôs AHCCCS health plan/program contractor. For members having private insurance, the non-emergency transportation should be coordinated through the insurance carrier if the transportation is a covered benefit.

Table of Contents - Chapter 50.000

Standards for Payments

50.000 Standards for Payments

This chapter provides information on claims and encounter submission and receipt of payment by CRS contractors for services rendered under the CRS Program.

50.100 Scope of the ADHS' Liability for Payments to Contractors

1. The ADHS shall bear no liability for the provision of CRS services or the completion of a plan of treatment to any member or eligible individual beyond the date of termination of such individual's eligibility and enrollment.
2. All payments to contractors shall be made pursuant to the terms and conditions of contracts executed between contractor and the ADHS, and in accordance with Administrative rules.
3. CRS Regional Contractors are responsible for any and all subcontracts executed with other parties for the provision of either administrative or management services for the CRS Program, medical services, covered services or for any other purpose.

50.200 Claims Submission

1. CRS Regional Contractors shall develop and maintain claims payment systems capable of processing, cost avoiding, and paying claims. For claims submitted for state-only payments, claims submission deadlines shall be calculated from the date of service/date of discharge. For AHCCCS covered claims, the submission deadline shall begin with the date of service/discharge or, in the case of AHCCCS retro-eligibility, the date of the eligibility posting, whichever is later. A CRS Regional Contractorôs claims payment system, as well as the prior authorization and concurrent review process, must minimize the likelihood of having to recoup previously paid claims. Any individual recoupment in excess of $50,000 per provider within a contract year must be approved in advance by CRSA. CRSA must be notified of any cumulative recoupment greater than $50,000 per provider per contract year. A CRS Regional Contractor shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim, without prior approval from CRSA, unless the recoupment is a result of fraud, data validation, or audits conducted by CRSA or the AHCCCSA, Office of Program Integrity.
2. CRS providers are reimbursed for covered services by CRS Regional Contractors. CRS Regional Contractors are responsible for the processing and adjudication of claims presented by CRS providers according to the terms of their contracts with those providers. CRS Regional Contractors shall ensure that 90% of all clean claims are paid

within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the CRS Regional Contractorôs specified claim mailing address. The paid date of the claim is the date on the check or other form of payment. [42 CFR 447.45(d)]

3. CRS Regional Contractors submit claims and encounter information to ADHS for program and financial management purposes. The complete, accurate, and timely reporting of encounter data is crucial to the success of the CRS program. CRSA uses encounter data to pay reinsurance benefits, set capitation rates, and to determine compliance with performance standards. CRS Regional Contractors shall submit encounter data to CRSA for all services for which the CRS Regional Contractor incurred a financial liability. Paid claims should be reconciled to the encounters to ensure that all paid claims have been encountered to CRSA.
4. Remittance advices accompanying CRS Regional Contractorôs payments to providers must contain, at a minimum, adequate descriptions of all denial and adjustments, the reasons for such denials and adjustments, the amount billed, the amount paid, and their right to file a claim dispute. (See Section 50.500)
5. Fast payment discounts and slow payment penalties shall be applied as of 07/01/06 as follows:
   A. For hospital clean claims paid within thirty days of the date the clean claim was received, the CRS regional contractor shall pay ninety-nine percent of the rate.
   B. If the hospital's clean claim is paid after thirty days but within sixty days of the date the clean claim was received, the CRS regional contractor shall pay one hundred percent of the rate.
   C. If the hospital's clean claim is paid any time after sixty days of the date the clean claim was received, the CRS regional contractor shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the clean claim until the date of payment. When a fee is paid, the subcontractor must report the fee separately from the health plan paid amount on the encounter. The fee should be reported in the 837 CAS adjustment loop using reason code ñ85ò.
6. The CRS Regional Contractorsô claims receipt guidelines shall be as follows:
   A. Initial receipt of claims must be within six months of the claim submission dates described in 50.200.1, unless a shorter time period is specified in contract.
   B. Claims received beyond the six-month time frames defined above shall be denied.

C. For claims received within the six-month time frame, the provider has up to twelve months from the date of service to resubmit a clean claim.
D. Claim receipt requirements pertain to both contracted and non-contracted providers.

7. CRS Regional Contractors are required to accept HIPAA compliant electronic claims transactions from any provider interested and capable of electronic submission; and must be able to make claims payments via electronic funds transfer. CRS Regional Contractors shall monitor the ratio of electronic claims to hard copy claims received into the claims processing system, the ñtime to processò electronic claims versus hard copy claims, the effect that the volume of electronic claims processing has on claims processing metrics, and the effect that electronic claims processing has on the CRS Regional Contractors quality standards (goals). In addition, CRS Regional Contractors shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:
   A. CRS Regional Contractors must be able to make claims payments via electronic Funds Transfer by June 30, 2006; and
   B. CRS Regional Contractors are required to receive and pay 25% of all claims (based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs) electronically by June 30, 2006.
8. The CRS Regional Contractors shall develop and maintain an electronic health information system that collects, integrates, analyzes and reports data. The system shall provide information on areas including, but not limited to, service utilization, claim disputes and appeals. [42 CFR 438.242(a)] The CRS Regional Contractors will ensure that changing or making major upgrades to the information systems effecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least seven months before the anticipated implementation date, the CRS Regional Contractors shall provide the system change plan to CRSA for review.
9. Claims submitted to the CRS Regional Contractors shall include:
   A. Completion of all fields on the appropriate claim forms;
   B. The Provider Services Requisition (PSR) authorization number;
   C. Valid service-specific diagnostic and procedural codes;
   D. Usual customary charges, which shall be broken out for each valid code submitted;
   E. Accurate modifiers, where appropriate;
   F. Operative report for surgical procedures;
   G. Physiciansô orders and progress notes for durable medical equipment (DME);

H. All supportive documentation (reports, progress notes, orders) for services other than surgery (e.g. ICU visits, consultations, admissions); and

I. All Explanations of Benefits (EOB) that relate to the claim (CRS is the payor of last resort).

10. Claims submitted without the above information or with inaccurate codes will automatically be returned to the provider for proper resubmission or other disposition.

11. CRS Regional Contractors shall have an audit process and policy in place to identify claims that are overpaid or underpaid and a process to recover overpayments and to resolve underpayments within 12 months of the initial payment.

A. CRS Regional Contractors shall conduct monthly audits of adjudicated claims to identify claims processing errors and erroneously paid claims. The claims audited will be:

i. A random selection of 5% of adjudicated claims;

ii. Actual adjudicated claims for Professional, Facility (Inpatient and Outpatient), Dental and Pharmacy.

B. CRS Regional Contractors shall utilize the Overpayment and Underpayments Tracking Log (see 12.D. below) and the results of audited adjudicated claims (see 11. A.) to analyze the causes of processing errors, overpayments, and underpayments and develop and implement interventions to reduce the number and causes of errors, overpayments, and underpayments.

C. CRS Regional Contractors shall make timely revision to claims processing policies and processes based on any interventions identified in 11. B. and submit any revised policies and procedures to CRSA with the Quarterly Overpayments and Underpayments Log within ninety (90) days of the policy and procedure changes.

D. CRS Regional Contractors shall notify CRSA immediately if the contractor is planning to recoup from any one provider an amount which will bring the total contract year net recoupment for that provider to an amount over $50,000.

E. CRS Regional Contractors shall implement a policy for the methods of recoupment and/or adjustment of a claim overpayment. CRSA approved methods of recoupment/adjustment are:

i. Reduction of subsequent providerôs payment if funds allow, or

ii. Requested refund of overpayment, (see sample refund letter), if providerôs account is not sufficient to accommodate reduction of payment.

F. CRS Regional Contractors shall implement a policy for the adjustment of underpayment of claims. The CRSA approved

method of adjusting underpayment of claims is to adjust the provider's payment (within 12 months of the original claim payment date) and to include notation of the adjustment within the remittance advice.

G. CRS Regional Contractors shall void/adjust the original encounter when a recoupment is made due to the identification of an erroneously paid claim (claim that should have originally been denied) or when a recoupment is made due to incorrect data or processing, e.g., when demographic, clinical or financial data is changed).

12. The following reports are due to CRSA on a monthly/quarterly basis or more frequent if requested by CRSA.
    A. Monthly Claims Aging Reports listing the amount of claims received and the length of time they have been in the CRS Regional Contractor's system to be paid. (Three monthly reports can be submitted each quarter.)
    B. Monthly Claims Inventory Report listing total work-in-process comprised of unprocessed claims received from providers for adjudication. *Unprocessed claims* have not yet been paid, denied, or pended. This report should be a snapshot at the end of the month. (Three monthly reports can be submitted each quarter.)
    C. Monthly Pended Claims Report listing the amount of claims received that are pended, the reason they are pended (e.g., internal claims review), and the length of time they have been in the CRS Regional Contractor's system as pended. This report should be a snapshot at the end of the month. (Three monthly reports can be submitted each quarter.)
    D. Quarterly Overpayments and Underpayments Tracking Log Report containing elements as defined by CRSA (see attachment A at the back of this chapter).
    E. Monthly Claim to Encounter reconciliation containing elements as defined by CRSA (see attachment E at the back of this chapter). (Three monthly reports can be submitted each quarter.)
    F. Quarterly Deleted Encounters Log containing elements as defined by CRSA (see attachment F at the back of this chapter).
    G. Monthly Claims Accuracy/Data Integrity Report containing elements as defined by CRSA (see attachment G at the back of this chapter). (Three monthly reports can be submitted each quarter.)
13. Claims processing personnel shall be trained to process the CRS claims.

A. CRS Regional Contractors shall maintain personnel records that ensure the contractors claims processors are trained or certified as claims processors.
B. CRS Regional Contractors shall require the claims processors have current and up to date training on claims processing.
C. CRS Regional Contractors shall maintain a Claims Processing Training log to be provided to CRSA quarterly or more frequently if requested by CRSA (see attachment B at the end of this chapter).
D. CRS Regional Contractors shall maintain sign-in sheets (see attachment C at the end of this chapter), training log and associated materials for all in-service training sessions.
E. CRS Regional Contractors shall have a representative attend the AHCCCS Quarterly Encounter Meetings on a regular basis.
F. CRS Regional Contractors shall maintain current and complete copies of the AHCCCS Claims Clues and Encounter Keys publications and sign-off distribution lists of all personnel responsible for AHCCCS claims/encounter processing or pend correction, ensuring the AHCCCS claim/encounter processing or pend correction personnel have read the information provided within the publications. Copies of the sign-off distribution lists shall be provided to CRSA at the annual site review.
G. CRS Regional Contractors shall implement any major changes in CRS claims and/or encounter processing as defined by CRSA as a result of information provided in the Claims Clues and Encounter Keys publications.
H. CRS Regional Contractor claims processing personnel shall complete all claims and/or encounter processing training provided by CRSA.

50.300 Collecting Payments for CRS Services

This section pertains to the requirements for CRS Regional Contractors obtaining payment for services provided to CRS members. This includes coordination of benefits and member responsibilities. CRSA requires CRS Regional Contractors to be responsible for coordination of benefits for services provided. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery.

50.301 Coordination of Benefits

1. Since the State of Arizona is the payor of last resort for the state only CRS population while AHCCCS is, in most instances, the payor of last resort for the AHCCCS CRS population, the CRS program, as funded by the state and AHCCCS, shall be used as a source of payment for

covered services only after all other sources of payment have been exhausted. CRS Regional Contractors shall coordinate benefits in accordance with 42 CFR 433.135 et. seq., A.R.S. §36-2903, and A.A.C. R9-22-1001 et. seq. so that costs for services otherwise payable by CRS Regional Contractors are cost avoided or recovered from a liable first or third-party payer. CRS Contract Providers are to make all reasonable efforts to collect from insurance companies and other third party payors.

2. CRS Regional Contractors shall take reasonable measures to determine the legal liability of third parties who are liable to pay for covered services. CRS Regional Contractors shall cost-avoid a claim if it establishes the probable existence of a third party or has information that establishes that third party liability exists. However, if the probable existence of third party liability cannot be established or third party liability benefits are not available to pay the claim at the time the claim is filed, the CRS Regional Contractor must process the claim. If a CRS Regional Contractor knows that the third party insurer will not pay the claim for a covered services due to untimely claim filing or as the result of the underlying insurance coverage (e.g., the service is not a covered benefit), the CRS Regional Contractor shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. The CRS Regional Contractor is required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on untimely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.
3. If a member (other than a State Only 100% pay member) has insurance which covers the CRS services provided, the member (other than a State Only 100% pay member) shall not be billed the residual, regardless of the memberôs payment responsibility.
4. A CRS Regional Contractor is responsible for collecting payments from insurance companies, managed care organizations and all other third party payers in accordance with member and family insurance policies, the CRS Contractorôs contractual arrangements with the payers, and all applicable Arizona statutes.
5. AHCCCS requires that all AHCCCS members with a CRS eligible medical condition, without private insurance, enroll with CRS. For those members with a CRS eligible condition, with private insurance, enrollment with CRS shall be optional. AHCCCS Members with private insurance choosing not to enroll with CRS may seek the payment of applicable copays and deductibles from the AHCCCS health plan/program contractor with whom they are enrolled. When the private insurance is exhausted with respect to CRS covered conditions, the AHCCCS health plan/program contractor is required to refer the

member to CRSA for determination for CRS services. For those members with private insurance who are enrolled in the CRS program, the CRS Regional Contractors are responsible for applicable copays and deductibles related to the CRS condition. CRS Regional Contractors are not responsible for paying coinsurance and deductibles that are in excess of what the CRS Regional Contractor would have paid for the entire service per a written contract with the provider performing the service, or the AHCCCS Fee For Service (FFS) payment equivalent. If the CRS Regional Contractor refers the member for services to a third-party insurer (other than Medicare), and the insurer requires payment in advance of all co-payments, coinsurance and deductibles, the CRS Regional Contractor must make such payments in advance.

6. When services are provided by the CRS program, which are outside the covered benefits provided by the insurer, the insurer is not required to pay for those services. If the member is a State Only 100% pay member, the family or member is responsible to pay for the services not covered by third party insurance according to what the CRS Regional Contractor would have paid for the entire service per a written contract with the provider performing the service, or the AHCCCS Fee For Service (FFS) payment equivalent.
7. If the CRS Regional Contractor does not know whether a particular service is covered by the third party, and the service is medically necessary, the CRS Regional Contractor shall contact the third party and determine whether or not such service is covered rather than requiring the member to do so. In the event that the third party does not cover the service, the CRS Regional Contractor shall arrange for the timely provision of the service.
8. The requirement to cost-avoid applies to all CRS covered services. In emergencies, the CRS Regional Contractor shall provide the necessary services and then coordinate payment with the third-party payer. Further, if a service is medically necessary, the CRS Regional Contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving such service and that the member (other than a State Only 100% pay member) shall not be required to pay any coinsurance or deductibles for use of the other insurerôs providers.
9. The amount of the payment due from the insurer or other third party payor is as follows:
    A. Third party payors not included as health care services organizations as described under Title 20, Chapter 4, Article 9 shall be billed the providerôs usual and customary charges with payments subject to the payorôs requirements for deductible and coinsurance.
    B. If a third-party insurer (other than Medicare) requires the CRS member to pay any co-payment, co-insurance, or deductible, the CRS Regional Contractor is responsible for making these

payments, even if the services are provided outside of the CRSA network.

C. CRS Regional Contractors are generally responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. CRS Regional Contractors are responsible for adhering to the cost sharing responsibilities presented in the *AHCCCS Contractors Operations Manual (ACOM), Chapter 200, Claims, Medicare Cost Sharing for Members in Medicare FFS/HMO* (See http://www.ahcccs.state.az.us/Publications/GuidesManuals/ACOM/ACOM.pdf). CRS Regional Contractor shall have no cost-sharing obligation if the Medicare payment exceeds what the CRS Regional Contractor would have paid for the same service of a non-Medicare member.

10. CRS Regional Contractors shall not bill AHCCCS Health Plans for CRS services.
11. Post-payment recovery is necessary in cases where the CRS Regional Contractor was not aware of third-party coverage at the time services were rendered or paid for, or was unable to cost-avoid. The CRS Regional Contractor may retain up to one hundred percent (100%) of its third-party collections if all of the following conditions exist:
    A. Total collections received do not exceed the total amount of CRSA financial liability for the recipient;
    B. There are no payments made by AHCCCS related to fee-for-service, reinsurance or administrative costs (i.e., lien filing, etc.); and,
    C. State or federal law does not prohibit such recovery.
12. The CRS Regional Contractor shall identify all potentially liable third parties and pursue reimbursement from them except the CRS Regional Contractor shall not pursue reimbursement for Title XIX and Title XXI enrolled CRS members in the following circumstances unless the case has been referred to CRSA by AHCCCS or AHCCCSôs authorized representative:
    A. Uninsured/ underinsured motorist insurance;
    B. First and third party liability insurance;
    C. Tortfeasors, including casualty
    D. Restitution recovery;
    E. Workerôs compensation;
    F. Estate recovery; and,
    G. Special treatment trust recovery.
13. The CRS Regional Contractor shall report to CRSA all cases for which:

A. The CRS Regional Contractor identifies circumstances A through G above.
B. The CRS Regional Contractor shall cooperate with AHCCCSôs authorized representative in all collection efforts.

14. The CRS Regional Contractor may be required to report case level detail of third-party collections and cost avoidance including number of referrals on total plan cases. The CRS Regional Contractor shall communicate any known change in or addition to health insurance information, including Medicare, to CRSA, not later than 10 days from the date of discovery using AHCCCS approved correspondence or AHCCCS approved Third-Party Correspondence.

50.302 Member Responsibility

A. A member shall participate in the cost of care by paying for services in the amounts described in Chapter 20, Member Payment Responsibility Standards.
B. The CRS Regional Contractor shall be responsible for collecting co-payments specified in Chapter 20, Member Payment Responsibility Standards. Any required co-payments collected shall belong to the CRS Regional Contractor or providers.
C. Except for permitted co-payments, the CRS Regional Contractor or providers shall not bill or attempt to collect any fee from, or for, an AHCCCS recipient for the provision of covered services.
D. The CRS Regional Contractor shall ensure that a member with a payment responsibility category of less than or equal to 200% FPL is not denied services because of that memberôs inability to pay a co-payment or deductible.
E. The CRS Regional Contractor is responsible for collecting applicable payment amounts from members with a payment category of greater than 200%FPL. The CRS Regional Contractor shall not deny services because of a memberôs inability to pay a co-payment or deductible for State Only 100% pay members who have a third party insurance.
F. The CRS Regional Contractors may recover from a member what the CRS Regional Contractor has paid a provider up to the payments made by a third party payor to the member. The amount recovered from the member should not exceed the amount that the CRS Regional Contract paid to the provider. The CRS Regional contractor would not recover from a member if the third party payor assigned payment to the CRS Regional Contractor.
G. Claims for CRS services shall not exceed the CRS Regional Contractorôs or the subcontractorôs usual and customary rates.
H. A CRS Regional Contractor may bill a member or family for medical expenses incurred during a period of time when the member or family willfully withholds material information from the CRS Regional

Contractor or provides false information pertaining to CRS, AHCCCS, KidsCare, or private insurance eligibility or enrollment status that results in denial of payment due to failure to disclose such information or the provision of false information.

I. The CRS Regional Contractors or their designees must adhere to the prior authorization requirements of all health service organizations. Neither families nor the CRS Program are responsible for the payment of services where payment was denied by a third party payor due to the fact that the CRS Regional Contractor failed to comply with preauthorization or other utilization management procedures.

50.400 Denied Claims

1. CRS Regional Contractors will provide written notifications to providers for all claims that are denied in part or for which a partial payment is made.
2. Notifications must contain:
   A. Date of denial;
   B. Services being denied or not included in payment;
   C. Reason for the denial or reduction in payment; and
   D. Providersô right to file a claim dispute and how to do so.

50.500 Claim Dispute Process

50.501 Time Frame for Filing Claim Dispute

Claim disputes must be filed in writing with the CRS Regional Contractor no later than 12 months from the date of service, within 12 months of the date that AHCCCS eligibility is posted or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. See ARS 36-2903.01 (B) (4)

50.502 Claim Dispute Policy and Process

1. CRS Regional Contractors shall have in place a written claim dispute policy for providers regarding adverse actions taken by the CRS Regional Contractor. The policy shall be in accordance with applicable Federal and State laws, regulations and policies.
2. The Provider Claim Dispute policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claim dispute policy must be sent no later than 45 days of receipt of a claim.
3. All documentation received by the CRS Regional Contractor during the claim dispute process shall be dated upon receipt. Specific individuals shall be appointed with requisite experience to administer the claim dispute process. Each claim dispute shall be thoroughly

investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties. All claim disputes with the appropriate documentation shall be filed separately in a secure designated area and shall be retained in a reproducible format for five years following the CRS Regional Contractorô decision, the Administrationôs decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law. Each claim dispute file must contain documentation of the written claim dispute, acknowledgment letter, all documentation received during the claim dispute process, request for extension of decision (if applicable), other information relevant to the notice of decision of the claim dispute, notice of decision letter, documentation of reprocessing and paying the claim within ten business days of the date of the Decision (if the claim dispute is overturned), providerôs written hearing request (if applicable), and hearing request cover letter to AHCCCS (if applicable).

4. CRS Regional Contractors are required to track, trend and analyze claim disputes for purposes of detecting fraud and/or abuse and system improvement. Any suspected fraud and abuse detected must be reported consistent with the requirements in Chapter 80, Section 302 of this manual.

50.503 Filing a Claim Dispute

1. For a claim for CRS services rendered to a member, the provider shall file a written claim dispute with the CRS Regional Contractor under the timelines in this policy. A claim dispute shall specify in detail the factual and legal basis for the claim dispute and the relief requested.
2. Within five working days of receipt, the Provider shall be informed by letter that the claim dispute has been received.
3. The CRS Regional Contractor shall mail a written Notice of Decision of the claim dispute to the provider no later than 30 calendar days after the provider files the claim dispute with the CRS Regional Contractor, unless the provider and the CRS Regional Contractor agree to a longer period. Documentation of an extension of time must be maintained in the claim dispute file.
4. The CRS Regional Contractorôs written Notice of Decision shall include:
   A. The nature of the claim dispute
   B. The issues involved
   C. The reasons supporting CRS Regional Contractorô Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
   D. The Providerôs right to request a hearing by filing a written request for hearing to CRS Regional Contractor no later than

30 days after the date the Provider receives CRS Regional Contractorôs decision.

E. If the claim dispute is overturned, it is required that the CRS Regional Contractor shall reprocess and pay the claim in a manner consistent with the Decision within ten business days of the date of the Decision. The CRS Regional Contractor shall have a process for internal communication and coordination when an appeal or claim dispute decision is reversed.

5. If the Provider files a written request for hearing, CRS Regional Contractor must ensure that all supporting documentation is received by the AHCCCS, Office of Legal Assistance, no later than five working days from the date the CRS Regional Contractor receives the providerôs written hearing request from AHCCCS, Office of Legal Assistance. The file above sent by CRS Regional Contractor must contain a cover letter that includes:
   A. Providerôs name
   B. Providerôs AHCCCS ID number
   C. Providerôs address
   D. Providerôs phone number (if applicable)
   E. The date of receipt of claim dispute
   F. A summary of CRSA or its subcontractorsô actions undertaken to resolve the claim dispute and basis of the determination
6. The following material shall be included in the file noted in step # 5 sent by CRS Regional Contractor:
   A. Written request for hearing filed by the Provider
   B. Copies of the entire file which includes pertinent records; and CRS Regional ContractorsôDecision
   C. Other information relevant to the Notice of Decision of the claim dispute
7. If CRS Regional Contractorsô decision regarding a claim dispute is reversed through the appeal process, CRS Regional Contractors shall reprocess and pay the claim in a manner consistent with the decision within ten business days of the date of the decision.
8. A provider claim dispute log shall be maintained for all claim disputes and provided to CRSA on a monthly basis (see attachment D at the end of this chapter).

Table of Contents - Chapter 60.000

Grievance System
Grievance, Appeal, and State Fair Hearing Processes for a CRS Enrolled Member

Table of Contents - Chapter 60.000 continued

Grievance, Appeal, and State Fair Hearing Processes for a CRS Enrolled Member

60.000 Grievance, Appeal, and Hearing Processes For A CRS Enrolled Member

60.100 Purpose

This chapter presents the CRS Programôs grievance, appeals, and administrative hearing processes for CRS enrolled members. This policy does not apply to actions or decisions that reduce a memberôs CRS benefits as a result of changes in state or federal law.

60.200 General Standards

60.201 Policies

1. CRS Regional Contractors shall maintain internal policies and procedures for grievance and appeal resolution processes that meet CRSA standards as described in this chapter.
2. Members and/or their representatives shall be informed about grievance and appeal procedures at the time of eligibility contact, upon request, or when changes occur in the policy.
3. Providers shall be given a copy of the member grievance and appeal policies at the time of contract, upon request, or when changes occur in the policies.
4. The CRS Regional Contractors shall ensure that punitive action is not taken against a provider who supports a memberôs grievance, or appeal, or who requests an expedited resolution to an appeal.
5. The CRS Regional Contractors shall ensure that individuals who make decisions on grievances and appeals are individuals:
   A. Who were not involved in any previous level of review or decision-making, and
   B. For medical necessity decisions or cases involving clinical issues, are health professionals who have the appropriate clinical expertise in treating the memberôs condition or disease.

60.202 Records

1. All records obtained for the CRS Program grievance and appeal processes are filed separately in a secure, designated area, and are retained in reproducible format for a minimum of six years.

2. The files must contain documentation of all acknowledgment, investigation and resolution activities related to each grievance and appeal.

60.203 Date of Filing

1. CRSA and the CRS Regional Contractors will consider the grievance, appeal, or State Fair Hearing request as filed on the date it is received by CRSA or the CRS Regional Contractor.
2. All written grievances and appeals and any incoming correspondence related to grievances and appeals must be date stamped upon arrival.

60.204 Reasonable Assistance

1. A CRS Regional Contractor shall provide reasonable assistance to members in completing forms and taking other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD (teletypewriter/telecommunications device for the deaf, and text telephone) and interpreter capability.

60.205 Computation of Time

1. Computation of time in calendar days begins the day after the act, event, or decision and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.
2. Computation of time in business days begins the day after the act, event or decision and includes all business days.

60.300 Grievance Process

60.301 Who May File

1. A Member or a memberôs parent or guardian may file a grievance.
2. A provider who is acting as the memberôs authorized representative may file a grievance on behalf of a member with the written consent from the member.

60.302 Time Frame for Filing a Grievance with CRSA or CRS Regional Contractor

A grievance, either orally or in writing, may be filed with CRSA or the CRS Regional Contractor at any time. As CRSA desires to have issues resolved as expeditiously as possible, the member or his/her representative should be encouraged to file directly with the CRS Regional Contractor.

60.303 Time Frame for Standard Disposition of a Grievance

1. The CRS Regional Contractor shall acknowledge receipt of each grievance orally or in writing no later than five (5) business days after

receipt. Potential quality of care concerns must have written acknowledgement.

2. The CRS Regional Contractor shall complete disposition and provide oral or written notice to the member of the grievance resolution as expeditiously as possible. Potential quality of care resolutions require a written notice to the grievant. Most grievances should be resolved within ten (10) business days; but, in no case longer than ninety (90) calendar days.

60.304 Grievance Resolution

1. CRS Regional Contractors shall have written policies and procedures for reviewing, evaluating and resolving grievances, regardless of who within the organization receives the grievances, that include:

   A. Documenting each grievance raised, when and from whom it was received;
   B. That is the responsibility of the CRS Regional Contractorôs Quality Management Coordinator to make a prompt determination of whether the grievance is a non-quality of care concern or a quality of care concern and assigning a severity level (Severity levels are defined at the back of this chapter. Zero equals non-quality of care and one and above equal quality of care issues);
   C. Determining priority status (See definitions at the back of this chapter);
   D. That all Quality of Care Issues are resolved in compliance with Ch. 80, Section 80.302;
   E. Assisting the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue;
   F. Ensuring confidentiality of all member information; and
   G. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance on both an individual and system level, including but not limited to:
      1) Interventions, including the provision of immediate medical needs as approved by the CRS Regional Medical Director;

      2) Monitoring of the outcome of the interventions;

      3) Incorporation of the interventions, if successful, into the CRS Regional Contractor system of care to reduce/eliminate the likelihood of the issue reoccurring;

4) Follow-up with the member that includes, but is not limited to:
   a) Assistance as needed to ensure that the immediate health care needs are met; and
   b) Closure/resolution letter on the Regional Contractorôs letterhead that provides sufficient detail to ensure all covered, medically necessary care needs are met; contact name/title and telephone number to call for assistance or to express any unresolved concerns; the name, title and credentials of the person signing the letter; and, if applicable, the Memberôs AHCCCS ID number.
      i. For non-quality of care resolution letters use letter #3, found at the back of this chapter, as a template;
      ii. For quality of care resolution letters use letter #4 as a template.

H. Documenting closure of the review.

2. Additional actions by the Regional Contractors may be necessary, based on individual case circumstances, before a case is closed. These actions may include:
   A. if the case was received from CRSA or if CRSA desires to review the investigative steps and proposed resolution, submission of the entire file with all documentation to CRSA;
   B. referring/reporting the issue to appropriate regulatory agency, AHCCCS, Child or Adult Protective Services and CRSA for further research/review or action;
   C. notifying the appropriate regulatory/licensing board or agency and CRSA when a health care professional's, organizational providerôs or other providerôs affiliation with their network is suspended or terminated because of quality of care issues;
   D. additional interventions/approaches if the original intervention is not successful or additional actions are required to fix the system;
   E. in-services documented through attendance sign-in sheets and notes;
   F. new policies and procedures; and/or
   G. referral to the CRSA Peer Review Committee.

60.400 Appeal Process

60.401 Who May File

1. A Member or a memberôs parent or guardian may file an appeal.

2. A provider, acting on behalf of the member, with the memberôs written consent, may file an appeal.

60.402 Requirements for Appeal Process

1. The CRS Regional Contractor shall acknowledge receipt of each appeal in writing no later than five (5) business days after receipt of a standard appeal and within one business day of receipt of an expedited appeal.
2. The CRS Regional Contractor shall provide a reasonable opportunity for a member or his/her representative to present evidence, and allegations of fact or law, in person and/or in writing. The CRS Regional Contractor shall inform the member of the limited time available for such presentation in the case of an expedited resolution.
3. The CRS Regional Contractor shall provide the member and representative the opportunity, before and during the appeal process, to examine the memberôs case file, including medical records, documents, and records considered during the appeal process, not protected from disclosure by law.

4. The Regional Contractor shall notify CRSA immediately if the appeal request makes mention of any quality of care issues of severity level two or above.

5. All letters sent out during the appeals process shall follow the language of the appropriate templates found at the back of this chapter; be sent on the Regional Contractorôs letterhead; identify the name, title and phone number of the person who is sending the response; and, if applicable, include the memberôs AHCCCS ID number.

60.403 Time Frame for Filing an Appeal

A member or a provider acting as the designated representative and with the memberôs consent must appeal either orally or in writing to the CRS Regional Contractor within sixty (60) days after the date of the Notice of Action.

60.404 Standard Resolution of an Appeal

1. For standard resolution of an appeal, the CRS Regional Contractor shall resolve the appeal and mail the written Notice of Appeal Resolution (letter #7) to the member within thirty (30) calendar days from the day the CRS Regional Contractor receives the appeal.
2. If the member requests an extension of the 30-day time frame in subsection (1), the CRS Regional Contractor shall extend the time frame up to an additional fourteen (14) days.

3. If the CRS Regional Contractor needs additional information and the extension is in the best interest of the member, the CRS Regional Contractor shall extend the time frame in subsection (1) up to an additional fourteen (14) days. If the CRS Regional Contractor extends the time frame, the CRS Regional Contractor shall:
   A. Give the member written notice (Notice of Extension of Resolution using Sample letter #6) of the reason for the decision to extend the time frame, and
   B. Issue and carry out the resolution as expeditiously as the memberôs health condition requires but no later than the date the extension expires.

60.405 Expedited Resolution of an Appeal

1. The CRS Regional Contractor shall establish and maintain an expedited review process for appeals from a member/memberôs representative or the provider (in making the request on behalf of the member or supporting the memberôs request) that taking the time for a standard resolution could seriously jeopardize the memberôs life or health or ability to attain, maintain or regain maximum function.
2. The CRS Regional Contractor shall conduct an expedited appeal if:
   A. The CRS Regional Contractor receives a request for an appeal from a member/memberôs authorized representative and the CRS Regional Contractor determines that taking the time for a standard resolution could seriously jeopardize the memberôs life or health, or ability to attain, maintain, or regain maximum function;
   B. The CRS Regional Contractor receives a request for an expedited appeal from a member/memberôs authorized representative who believes that taking the time for a standard resolution could seriously jeopardize the memberôs life or health, or ability to attain, maintain, or regain maximum function;
   C. The CRS Regional Contractor receives a request for an expedited appeal directly from a provider, with the memberôs written consent, and the provider indicates that taking the time for a standard resolution could seriously jeopardize the memberôs life or health, or ability to attain, maintain, or regain maximum function.
3. For expedited resolution of an appeal, the CRS Regional Contractor shall resolve the appeal, make reasonable efforts to provide oral notice and mail the written Notice of Appeal Resolution to the member within three (3) business days from the day the CRS Regional Contractor receives the expedited appeal request.

60.406 Time Frame for an Expedited Appeal Resolution

1. If the CRS Regional Contractor denies a request for an expedited resolution, it must transfer the appeal to the 30-day time frame for a standard appeal. The CRS Regional Contractor must make reasonable efforts to give the CRS member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of the denial of an expedited resolution.
2. Expedited appeals must be resolved within three (3) business days of receipt of the request. If the member requests an extension of the 3-business day time frame, the CRS Regional Contractor shall extend the time frame up to an additional fourteen (14) days.
3. If the CRS Regional Contractor needs additional information and the extension is in the best interest of the CRS member, the CRS Regional Contractor shall extend the time frame up to an additional fourteen (14) days. If the time frame is extended, the CRS Regional Contractor shall:
   A. Give the member written notice (Notice of Extension of Resolution) of the reason for the decision to extend the time frame; and
   B. Issue and carry out the determination as expeditiously as the CRS memberôs health condition requires and no later than the date the extension expires.

60.407 Notice of Appeal Resolution

The CRS Regional Contractor shall use the Notice of Appeal Resolution letter # 7.

60.500 Request for Review Process by ALTCS/Acute Care Contractors

60.501 Request for Review Process

1. Request for Review means a request by an AHCCCS Health Plan/Program Contractorôs Medical Director asking the CRS Regional Contractor Medical Director to review a new service denial or a reduction, suspension, or termination of a previously authorized service for a Title XIX or Title XXI member (See the Notice of Action section in Chapter 80 for procedures related to sending out the denial notice).
2. When a denial is deemed a ónon-covered CRS service,ô the AHCCCS health plan/program contractor Medical Director may appeal the decision in writing with the CRS Regional Contractor Medical Director no later than ten (10) business days of the date of decision by asking for a Request for Review.

3. The CRS Regional Contractor Medical Director must respond within ten (10) business days from date of receipt of the Request for Review from the AHCCCS health plan/program contractor.
4. A Notice must be sent by the CRS Regional Contractor advising the ALTCS/Acute Care Contractor Medical Director of the review decision and of the right of the ALTCS/Acute Care Contractor, in the event that the ALTCS/Acute Care Contractor disagrees with the decision, to file a request for hearing with AHCCCS Administration within thirty (30) days of receipt of decision by the CRS Regional Contractor. See letter #8 at the back of this Chapter for the language to be included in the Notice.
5. If the ALTCS/Acute Care Contractor provides the service that CRS has denied, and the AHCCCS Hearing Decision determines that the service should have been provided by CRS, CRS shall be financially responsible for the costs incurred by the ALTCS/Acute Care Contractor in providing the care.

60.600 State Fair Hearing Process

60.601 Request for a State Fair Hearing

1. A member may request a State Fair Hearing of the CRS Regional Contractor resolution to uphold its original adverse decision.

60.602 Filing Timeframes

1. The CRS Regional Contractor will forward AHCCCS (Title XIX and Title XXI member) requests for State Fair Hearings to AHCCCS Office of Legal Assistance within five (5) business days of receipt.

   Office of Legal Assistance
   AHCCCS Administration
   701 East Jefferson
   Phoenix, AZ 85034
2. The CRS Regional Contractor will forward ADHS (non-AHCCCS member) requests for State Fair Hearings to CRSA within five (5) business days of receipt.

   Arizona Department of Health Services
   Office of the Director
   Counsel and Legal Support Unit
   150 North 18th Avenue, Suite 500
   Phoenix, Arizona 85007-3247

60.603 Request for an Expedited State Fair Hearing

A member may request an expedited State Fair Hearing on the CRS Regional Contractor resolution of an expedited appeal. The request shall be in writing, submitted to and received by the CRS Regional Contractor no later than thirty (30) calendar days after receipt of the CRS Regional Contractor Notice of Appeal Resolution.

60.604 Time Frame for Resolution of an Expedited State Fair Hearing

Within three (3) business days of the receipt of a response from an expedited State Fair Hearing for AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members), AHCCCS or ADHS shall mail to the member the response from the State Fair Hearing. AHCCCS or ADHS shall make reasonable efforts to provide oral notice of the decision.

60.605 Denial of a Request for a State Fair Hearing

1. AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) shall deny a request for a State Fair Hearing under A.R.S. § 41-1092, et seq., upon written determination that:
   A. The request for hearing is untimely;
   B. The request for hearing is not for an action permitted under this policy;
   C. The request for hearing is moot, based on the factual circumstances of each case, as determined by AHCCCS or ADHS, based on factual circumstances of each case; or
   D. The sole issue presented is a federal or state law requiring an automatic change adversely affecting some or all enrollees.

60.606 Withdrawal of a Request for a State Fair Hearing

1. AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) shall accept a written request for withdrawal from the member if the Notice of Hearing has not been mailed.
2. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) has mailed a Notice of Hearing, AHCCCS (Title XIX and Title XXI members) shall forward the written request for withdrawal to the AHCCCS Office of Legal Assistance (OLA) or ADHS (non-AHCCCS members) will forward the written request for the withdrawal of the Notice of Hearing to the ADHS Counsel and Legal Support Unit.

60.607 Processing Request for a Hearing

1. If the member files a request for hearing, CRS Regional Contractors must ensure that the case file and all supporting documentation is received by the AHCCCSA, Office of Legal Assistance (Title XIX and Title XXI members), or ADHS (non-AHCCCS members) within five (5) business days of receipt of the request. The file provided by CRS Regional Contractors must contain a cover letter that includes:
   A. CRS member's name, AHCCCS ID number, address, and phone number (if applicable);
   B. Date of receipt of appeal;
   C. Summary of the CRS Regional Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution;
   D. The CRS member's written request for hearing;
   E. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records;
   F. Copy of CRS Regional Contractor's Notice of Appeal Resolution; and
   G. Other information relevant to the resolution of the appeal.

60.608 Continuation of Services While the CRS Regional Contractor Appeal and the State Fair Hearing are Pending

1. For the purposes of this Section, timely filing means filing on or before the later of the following:
   A. Within ten (10) calendar days after the date that the CRS Regional Contractor mails the Notice of Action, or
   B. The effective date of the action as indicated in the Notice of Action.
2. The CRS Regional Contractor shall continue the member's services if:
   A. The member files the appeal timely;
   B. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
   C. The services were ordered by an authorized CRS provider;
   D. The original period covered by the original authorization has not expired; and
   E. The member requests continuation of services.
3. If, at the member's request, the CRS Regional Contractor continues or reinstates the member's services while the appeal is pending, the CRS Regional Contractor shall continue services until one of the following occurs:
   A. The member withdraws the appeal;
   B. Ten (10) calendar days pass after the CRS Regional Contractor mails the Notice of Appeal Resolution to the member, unless the member, within the 10 calendar day time frame, has requested in writing a State Fair Hearing with continuation of benefits until the CRS Regional Contractor decision is reached;

C. AHCCCS (Title XIX and Title XXI members) or CRSA (non-Title XIX and non-Title XXI members) mails a decision adverse to the member; or
D. The time-period or service limits of a previously authorized service have been met.

4. If AHCCCS (Title XIX and Title XXI members) or CRSA (non-Title XIX and non-Title XXI members) upholds the CRS Regional Contractors action, the CRS Regional Contractor may recover the cost of the services furnished to the member while the appeal is pending if the services were furnished solely because of the requirements of this policy.

60.609 Reversed Appeal Resolution

1. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the CRS Regional Contractor shall provide the disputed services promptly, and as expeditiously as the memberôs health condition requires.
2. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CRS Regional Contractor shall pay the provider for those services.

60.608 Providers

The grievance process for CRS staff and contracted providers follows the same guidelines as described in section 60.300.

60.700 Tracking and Trending of Member and Provider Grievances

1. Contractors must ensure that member health records, as well as the records described in 60.202, are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse and grievances. Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, HIPAA and 42 CFR 431.300 et seq.
2. Information related to coverage and payment issues must be maintained for at least five years following final resolution of the issue, and must be made available to the member, provider and/or CRSA authorized staff upon request.

3. The CRS Regional Contractor shall log and track all member/provider grievances, denials, appeals and state fair hearings, regardless of who within the organization receives the grievance, appeal or request for a state fair hearing.
4. The grievance, denial, appeal and state administrative hearing log must be completed using CRSA specified forms and/or databases.
5. The logs and/or databases must be submitted to CRSA by the 15th of the month for the preceding month.

Letter #1
Non-quality of care grievance acknowledgement letter *(On Regional Contractor letterhead)*

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the grievance)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

It is important to us that you are happy with the care and service that you get from us. We have received your complaint and we will be looking into it. As soon as possible, we will send you a response.

Thank you for letting us know about your problem. If you have any questions, you can call XXXXX, at (602) XXX-XXXX.

Sincerely,

(*Name and credentials)*
(*Title*)

Cc:
XXX

Letter #2
Non-quality of care grievance resolution *(On Regional Contractor letterhead)*

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

DATE

(*Name of person filing the grievance)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We have looked at your complaint. We have found (or decided) . We have made this decision based on *(Please include the legal citations or authorities supporting the determination, if applicable.)*

Thank you for letting us know about your complaint. If you have questions, you may call me at (XXX) XXX-XXXX.

Sincerely,

*Name and credentials*Title

Letter #3
Appeal Acknowledgement Letter (On Regional Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the appeal)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We have received your appeal and will consider it. A written response will be sent to you within 30 days.

Thank you for contacting us about this issue. The quality of health care of all of our members is important to us. You can call XXXXXXXX, at (602) 000-0000 if you have any questions.

Sincerely,

Name and credentials Title

Cc:
XXXX

Letter #4
Request for Extension of Appeal Resolution Time Frame Letter (On Regional Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the appeal*
Address
City, State, Zip)

RE: *(CRS Member Name, Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We would like to take up to 14 extra days to look into your appeal. *).* These extra days to make a decision benefit you by allowing us to have more complete information about the services you want given. We will make every effort to complete our review as soon as possible. We will take no longer than a total of 44 days from the day we received your appeal.

On behalf of (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding. You can contact XXXXXXXX, at (602) 000-0000 if you have any questions regarding this issue.

Sincerely,

XXXXXXXXXXX
Name and credentials
Title
Cc: XXXX

Letter #5
Notice of Appeal Resolution *(On Regional Contractor letterhead)*

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

DATE
(Name of person filing the grievance
Address
City, State, Zip)

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We received your letter of (*Date)*, asking that we look again at our decision to _____ . (*repeat decision in layperson terms*)

We have looked at the decision again. We have decided (*that the first decision was right/* ***or****/ to change our decision to* [*describe decision in lay person's language*]_____. We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you can tell us you want a State Fair Hearing. You must ask for the hearing in writing within 30 days from the day you receive this Notice of Appeal Resolution. If we do not hear from you by then, our decision will be final.

If you are now getting a service that is being cut back or stopped, you have the right to ask that this service be continued during the time it takes to receive a decision from the State Hearing. You must ask for the State Fair Hearing and services to continue within ten calendar days from date of this letter. If the decision does not support your request, you may have to pay for the services in question.

If you have questions, you may call XXXX at (XXX) XXX-XXXX.

Sincerely,

Name and credentials

Title

Letter #6

(CRS Regional Contractor Letterhead)

Notice of Decision by CRS
on
AHCCCS Health Plan /Program Contractor Request for Review

I. Date

II.

III.

IV. To: Health Plan Name

V. Address

Re: (*Member name, CRS Member # and AHCCCS ID#*)

Dear: (*Plan Medical Director*)

We received your Request for Review dated _____ asking us to review our decision to _____.

After reviewing our original decision, we have decided (*that the first decision was right/* ***or****/ to change our decision to* _____.) We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you may file a request for a hearing with the AHCCCS Administration within 30 days of receipt of this letter.

If you have questions, please call us at *(XXX) XXX-XXXX.*

Sincerely,

_____
CRS Regional Medical Director

QUALITY OF CARE CONCERN SEVERITY LEVELS

Level 0- Track only:

No risk for it to be a quality of care concern, risk of harm, permanent damage, increased cost of care, lengthened stay, permanent damage, or potential media event. Concerns may be related to physical elements of the clinic and discourtesy.

Level 1- Concern that MAY impact the member if not resolved:

Potential unsafe home environment; non-compliance with appointment scheduling or wait time requirements; need for information or referral to resolve an issue.

Level 2- Concern that WILL impact the member if not resolved:

Including slow, or no responsiveness to a request for evaluation, treatment other request; member rights violation; inadequate case management; physician clinic cancellations; availability/timeliness of transportation for medical appointments.

Level 3- Concern that IMMEDIATELY impacts the member and is considered life threatening or dangerous

Including situations of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of an acute condition; denial of services deemed medically necessary by the member/provider; potential provider misconduct; issues with, or the potential for, adverse media coverage or the potential for a lawsuit; and issues referred by the AHCCCS Director's Office.

Level 4- Concern that no longer impacts the member but may have potential to be life threatening or dangerous to other members:

Unexpected death has resulted, directly or indirectly as a result of care given or omitted. Media coverage assured. Lawsuit filed or in process.
Examples include cases abuse and neglect; unexpected deaths; and cases from the Governor's Office, Legislature, or ADHS Director/Assistant Director's Office regardless of the nature

PRIORITY CATEGORY OF GRIEVANCES

Priorities are categorized in four groups:

High Risk-Including situations of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of an acute condition; denial of services deemed medically necessary by the member/provider; unexpected deaths; potential provider misconduct; issues with, or the potential for, adverse media coverage or the potential for a lawsuit; and issues referred by the AHCCCSA, ADHS Director's Office and or the Governor's Office.

Routine-Including slow, or no responsiveness to a request for evaluation, treatment other request; potential unsafe home environment; member rights violation; inadequate case management; availability/timeliness of transportation for medical appointments; non-compliance with appointment scheduling or wait time requirements; need for information or referral to resolve an issue. If there is absolutely no possibility that the complaint could impact the member in any way, it is to be tracked only, as a general grievance.

Track and Trend- Including non-quality-of-care concerns that may become quality of care concerns if a trend is identified.

Referral to other OCSHCN Sections, or other Agencies-Including eligibility issues; contract compliance; network issues; member fraud; compliance with statute or state plan; abuse or neglect; compliance with licensure standards; criminal offenses; etc. Fraud, abuse, neglect and criminal offenses are to be referred to the appropriate agency immediately upon identification.

Table of Contents - Chapter 70.000
Records

70.000 RECORDS

This chapter includes information on records that shall be maintained in support of the Arizona Children's Rehabilitative Services (CRS) Program. The sections include the types of records to be maintained and records management functions.

70.100 Types of Records Maintained for CRS Members

CRS Regional Contractors are to maintain medical payment and other related records as defined by this policy for each CRS member as required by this policy, licensing agencies, accreditation organizations, and/or state and federal laws.

70.101 Medical and Payment Records

1. Medical records, payment, and other records required to be maintained by this policy for CRS members are the property of the providers of record. All CRS members should have a medical record that is maintained by the CRS Regional Contractor or designated subcontractor.
2. CRS Regional Contractors must implement appropriate policies and procedures to ensure that the contractor and its providers have information required for:
   A. Effective and continuous patient care through accurate medical record documentation of each member's health status, changes in health status, health care needs, and health care services provided,
   B. Quality review, and
   C. Ongoing compliance monitoring of those policies and procedures conducted by the CRS Regional Contractor or its providers through a designated program.
3. CRS Regional Contractors must implement policies and procedures that address medical records and the methodologies to be used to:
   A. Ensure a legible medical record for each enrolled member who has been seen for medical appointments or procedures and/or receive medical/behavioral health records from other providers who have seen the enrolled member.

      Confirm that the record is kept up-to-date, well organized, and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member. However, the CRS Regional Contractor must maintain a

comprehensive record that incorporates at least the following components:

1) Member identification information on each page of the medical record (i.e., membersô name and CRS or Arizona Health Care Cost Containment System (AHCCCS) identification number),
2) Documentation of identifying demographics including the memberôs name, address, telephone number, CRS identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative,
3) Initial history for the member that includes family medical history, social history, and preventive laboratory screenings (the initial history for members under age 21 should include prenatal care and birth history of the memberôs mother while pregnant with the member),
4) Past medical history for all members that includes disabilities, diagnosed anomalies, previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, emergent/urgent care received, and communicable diseases, including human immunodeficiency virus (HIV),
5) Documentation initialed by a CRS provider to signify review of the following:
    a) Diagnostic information including:
        i. Laboratory tests and screenings,
        ii. Radiology and other imaging reports,
        iii. Physical examination notes, and
        iv. Other pertinent data (e.g., cognitive or other evaluations).
    b) Reports from referrals, consultants, and specialists,
    c) Emergency/urgent care reports,
    d) Hospital discharge summaries, and
    e) Behavioral health referrals and services provided, if applicable.
6) Immunization records (required for children but recommended for adult members, if available),
7) Dental history if available and current dental needs and/or services,
8) Audiology and speech evaluations or related treatment,
9) Current problem list,
10) Current medications,

11) Documentation as to whether an adult member has completed advance directives and copy of the directive,
12) Documentation related to requests for release of medical, payment, other pertinent information and subsequent release,
13) Specific release of information process for record requests and disclosures related to communicable disease, including HIV, and substance abuse information,
14) Documentation that reflects that diagnostic, treatment, and disposition information related to a specific member was transmitted to the primary care provider (PCP) and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care,
15) Documentation of a plan for transition from pediatric to adult care beginning at age 14,
16) Application/Referral Packet,
17) Condition-specific pertinent flow sheets and appropriate pediatric growth charts,
18) Referral information to and from outside agencies, physicians, AHCCCS health plans, and AHCCCS primary care physicians, if applicable, including records of CRS services provided by contracted or subcontracted providers, or non-contracted providers,
19) Multi-specialty, interdisciplinary team reports,
20) Audiometric reports,
21) Therapy reports (e.g., speech pathology),
22) Copies of pharmacy prescriptions and/or medication profile, and
23) Home health summaries.

B. Take into consideration professional and community standards and accepted and recognized practice guidelines.

C. Implement a process to assess and improve the content, legibility, organization, and completeness of member's health records.

D. Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants (e.g., physicians' assistants) are allowed to provide services.

E. Require that each contracted hospital maintain a medical record on a CRS member served that includes:
1) Physician or provider orders for the service,
2) Applicable diagnostic or evaluation documentation,

3) A plan of treatment,
4) A periodic summary of the memberôs progress towards treatment goals,
5) The date and description of service modalities provided, and
6) Signature/initials of the provider for the care rendered.

4. Medical records may be documented on paper or in an electronic format.
   A. For paper documentation, the record must be:
      1) Dated,
      2) Signed with an original signature and credential,
      3) Legible and either written in blue or black ink or typewritten, and
      4) Corrected with a line drawn through the incorrect information, a notation that the incorrect information was an error, the date when the correction was made, and the initials of the person altering the record. Correction fluid or tape is **not allowed**.
   B. A progress note is documented on the date that an event occurs. Any additional information added to the progress note is identified as a late entry (See A.A.C. R9-20-211(C), Client Records).
   C. For electronic documentation, including e-mail correspondence, there must be a method to:
      1) Indicate the identity of the person making an entry into the record and the date for each entry,
      2) Ensure that the information is not altered inadvertently, and
      3) Track when, and by whom, revisions to information are made.
   D. Electronic medical and payment records, including amended or corrected records, must be maintained by a backup system that conforms to the requirements of this policy and state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA) Security Regulations at 45 C.F.R. Part 164.
5. CRS Regional Contractors must have written policies and procedures addressing appropriate, confidential, and secure exchange of member information among providers, including behavioral health providers, and must conduct reviews to verify the following:
   A. A provider making a referral transmits necessary information to the provider receiving the referral,
   B. A provider furnishing a referral service reports appropriate information to the referring provider,

C. Providers request information from other treating providers as necessary to provide appropriate and timely care,
D. Information about services provided to a member by a non-network provider (e.g., emergency services, etc.) is transmitted to the member's PCP,
E. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP, and
F. Member information is shared when a member transfers/partial transfers with another CRS Regional Contractor in a manner that maintains confidentiality while promoting continuity of care.

6. Information from or copies of records may be released only to authorized individuals, and the CRS Regional Contractor must implement a process to ensure that unauthorized individuals cannot gain access to or alter member records.
7. Original and/or copies of medical records must be released only in accordance with Federal laws, State of Arizona laws, CRS policies, and contracts. CRS Regional Contractors must comply with HIPAA requirements and 42 C.F.R. § 431.300 et seq.
8. Upon appropriate release, the CRS Regional Contractor will forward documentation of inpatient and outpatient services to the referring source and/or the primary care physician. The original or a copy of this documentation shall be maintained in the member's medical record at the CRS Regional Contractor's location.
9. All CRS member records shall be pulled for upcoming clinic visits prior to the scheduled clinic.
10. Progress notes shall be filed into the medical record no later than 30 working days from the date of the clinic visit.
11. All medical records, both active and inactive, shall be made available to Children's Rehabilitative Services Administration (CRSA) for research as permitted by state and federal laws, inspection, and audit purposes.
12. Medical records shall be maintained in an organized, detailed, and comprehensive manner, conforming to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards or standards of other applicable nationally recognized accrediting organizations, and Arizona health care professional standards and practices.

70.102 Other Records and Statistical Information

CRSA collects data and information about CRS members to assist in the management and administration of the program. In addition, the CRS Program is subject to a variety of data collection and reporting requirements

from regulatory and funding agencies at the state and federal levels.

70.200 Records Management

Records management refers to safeguarding, storage, maintenance, and disclosure of medical information regarding CRS members.

70.201 Release of Confidential Health Information

1. CRS Regional Contractors and subcontractors must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, Title II and related regulations at 45 C.F.R. Parts 160 , 162, and 164; 45 C.F.R. Part 2; A.R.S. § 36-261(A)(5)(k); A.R.S. § 36-661 et seq.; A.R.S. §§ 36-501, 504, and 509; A.R.S. § 12-2291 et seq.; and other state and federal laws pertaining to disclosure of health information.
2. The Arizona Health Care Cost Containment System Administration (AHCCCSA) is not required to obtain written approval from a CRS recipient before requesting the recipientôs medical record. AHCCCSA shall be afforded access to all recipientsô medical records whether electronic or paper within 20 working days of receipt of request. CRSA may obtain a copy of a recipientôs medical records without written approval from the recipient if the reason for such request is directly related to the administration of the AHCCCS program.

70.202 Authority for Refusal to Disclose

Any request or demand for medical or payment information, disclosure of which is prohibited by Arizona law and by this subsection, shall be declined upon the authority of Arizona law, the provisions of this subsection, A.R.S. § 36-107 and A.R.S. § 36-136(G). If any employee is compelled, by subpoena or otherwise, to produce such medical information he/she shall respectfully decline to present or divulge the same, basing his/her refusal upon the provisions of law and this subsection prescribed there under and shall through established administrative channels seek the advice of the appropriate county attorney or the attorney general.

70.203 Confidentiality of Information Received from or through the Federal Government

Notwithstanding anything in Arizona Administrative Code, state or federal laws, or this subsection to the contrary, any medical information contained in the records of this department, the source of which is the Secretary of the U.S. Department of Health and Human Services, or any person acting under him/her, or from any provider of services acting as such pursuant to U.S.

Public Law 89-97 any amendments thereto, shall be disclosed only as provided by federal law and the regulations promulgated there under.

70.204 Member Access to Medical Records and Payment Records

CRS shall ensure that parents and legal guardians of members less than 18 years of age and CRS members have access to all their own medical and payment records during regular business hours, unless circumstances require disclosure at other times for emergency medical care.

70.205 File Storage

CRS Regional Contractors are to provide adequate staffing to ensure that the medical record functions are accomplished efficiently and in a timely manner. This includes pulling records for clinics, physicians, and other authorized individuals, re-filing records accurately, and filing loose material (e.g., X-rays, lab reports, consultation reports, etc.) no later than one month following the clinic visit, and copying medical records with proper authorization as permitted by A.R.S. § 12-2291 et seq. and the HIPAA Privacy Regulations, 45 C.F.R. Parts 160 and 164. There shall be a minimum of one registered health information technologist (RHIT) or individual with the equivalent knowledge and experience in health information management and control in the clinic. The health information management unit will maintain a unit medical record on each individual receiving inpatient, outpatient, or ambulatory surgery services. It should be readily available to the physician and to other individuals as authorized by A.R.S. § 12-2291 et seq, the HIPAA Privacy Regulations, and other state and federal laws.

70.206 Security

Medical records for CRS enrolled individuals shall be housed in the medical records section of the outpatient clinic and shall be separate from the records of the contracting facility. CRS Regional Contractors are obligated to provide security in accordance with HIPAA and JCAHO standards, including physical and record security. The CRS Regional Contractor shall maintain payment records according to HIPAA security, state laws, federal laws, CRS policies, and contracts.

70.207 Record Retention

1. Active CRS medical records and source data, as defined by A.R.S. § 12-2291(7), shall be maintained by the providers contracted to render CRS hospital or clinical services in accordance with A.R.S. § 12-2297, accreditation standards, licensure requirements, and other state or federal law.

2. Inactive records are those for individuals who meet one of the following conditions:
   A. Have not been seen for over two years and do not have a future appointment,
   B. Have expired,
   C. Have moved out of state,
   D. Are no longer medically eligible,
   E. Have reached 21 years of age, or
   F. Have disenrolled voluntarily.
3. If the member is an adult, Arizona laws require that medical records be kept for at least six years after the last date of treatment. If the member is a child, medical records must be kept for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received services, whichever date is later. (A.R.S. § 12-2297).

Table of Contents - Chapter 80.000

Program Oversight

Attachments:

80.000 Program Oversight

This chapter includes information about the processes in place to ensure quality and consistency in the CRS program. It addresses CRS Regional Contractorsô financial reporting requirements, program reporting requirements, quality and utilization management requirements, and CRSA program evaluation activities.

80.100 Financial Reporting Requirements

1. CRS Regional Contractors will have a system in place to produce complete, timely, reliable, and accurate financial records in accordance with contract requirements for financial reporting. Contractor shall design and implement their financial operations system to ensure compliance with Generally Accepted Accounting Principles. Contractor shall also file with CRSA an annual (more frequently if required by CRSA) CMS-approved disclosure statement and related party transactions statement. CRSA shall evaluate all such statements to ensure that they conform to CMS requirements and, through its periodic audit and review procedures, shall ensure that the statements are complete and accurate. CRSA shall take immediate corrective action upon discovery of any failure to meet contract requirements.
2. CRS Regional Contractors receiving state funds shall comply with the certified financial and compliance audit provisions of the Office of Management and Budget (OMB) Circular A-128 or A-133, whichever is applicable, and the certified financial and compliance audit provisions of A.R.S. §35-181.03.
3. CRS Regional Contractors are required to provide CRSA with financial and cost information, in the manner specified by CRSA. Types of financial reports include:
   A. Cost reports, in the schedules, formats, and timing specified by CRSA. The cost report must include inpatient, outpatient, and clinic data;
   B. Audit report of CRS Regional Contractorôs annual cost reports or financial statements, performed by an independent Certified Public Accountant (CPA);
   C. Third party and family liability and collection reports, submitted in the format specified by CRSA; and
   D. Other financial, regulatory, or program monitoring reports, as requested by CRSA for program analysis and oversight.

80.200 Program Reporting Requirements

1. CRS Regional Contractors submit a variety of program reports and other data to CRSA to fulfill CRSA compliance responsibilities to funding agencies, and to assist CRSA in monitoring and oversight of the CRS program.
2. CRS Regional Contractors shall submit these reports and information in the format and specifications provided by CRSA.
3. CRS Regional Contractors shall furnish information and records relating to contract performance to CRSA upon request.

80.300 Delegated Quality Management/Performance Improvement Activities

80.301 Policies and Procedures and Requirements for Delegated Activities

1. The CRSA must oversee and be accountable for the QM/PI program; however, the CRS Regional Contractors must oversee and be accountable for any activities that are delegated to outside entities.

2. CRS Regional Contractors shall have policies and procedures that emphasize quality in all aspects of providing services to the CRS population. This requirement includes processes within the clinic setting as well as processes for monitoring other provider services outside of the clinic setting.

3. Delegation of any activities to another entity does not alleviate the Regional Contractorôs responsibility for ensuring quality. Documentation must be kept on file, and available to CRSA upon request, that shows the following requirements have been met for the delegated functions:
   A. A written agreement specifying the delegated activities and reporting responsibilities of the entity that provides for revocation of the delegation or other remedies for inadequate performance;
   B. An evaluation by the Regional Contractor of the entityôs ability to perform the activities prior to delegation;
   C. Ongoing monitoring of the performance and quality of services provided and a formal review at least annually; and
   D. Written evaluations and CAPs, as necessary.

80.302 Quality of Care Issues

1. The Regional Contractor is responsible for investigating all quality of care allegations involving its own clinic activities as well as other services provided directly or through provider sub-contracts, regardless of the source

of the allegation. Quality of care issues identified through the grievance or appeal processes are subject to the requirements below in 5., 6., and 7.

2. Substantiated allegations must be resolved on both individual case and system levels. Cases shall not be closed until the actions needed for resolution are completed and assessed and until any system breakdown or deficiency that allowed the lapse in quality care to occur is successfully addressed.

3. The Regional Contractor shall maintain Quality of Care files on each case that shall contain detailed documentation of the research, actions and outcomes. The files shall be available to CRSA on request.

4. In addition to the requirements to notify CRSA when quality of care issues are identified through grievances and appeals, CRSA also shall be notified immediately of all quality of care issues with an initial severity level of 2 or above, as defined at the end of this chapter, when the Regional Contractor identifies an issue through its own internal processes or through audits and reviews by outside agencies or consultants.

5. The Regional Contractor shall have written policies and procedures for reviewing, evaluating, and resolving quality of care issues, regardless of who within the organization receives the grievances, that include:

   A. Making a prompt determination of whether a grievance is a non-quality of care concern or a quality of care concern and assigning a severity level (Severity levels are defined at the back of this chapter. Zero equals non-quality of care and one and above equal quality of care issues.);
   B. Identifying how the Regional Medical Director is informed of quality of care issues, is involved in the assignment of severity levels, and oversees interventions and final resolutions;
   C. Immediately reporting initial severity level 2, 3, 4 to CRSAôs Division of Quality Management;
   D. Determining Quality of Care Categories (see table at the back of this chapter);
      1) main category; and
      2) subcategory;
   E. Immediately reporting to CRSA closing severity level when higher than initial severity level;
   F. Acknowledging receipt of the concern and explaining to the member or provider the process to be followed in resolving his or her concern through written correspondence. A Quality of Care Acknowledgement letter template (Attachment 1) is attached at the

end of this chapter for use under the Regional Contractors own letterhead and with the name, title, credentials, and telephone number of the person sending the letter.

G. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance determined to be a quality of care issue on both an individual and system level, including but not limited to interventions, including the provision of immediate medical needs as approved by the CRS Regional Medical Director.

H. Follow-up with the member that includes, but is not limited to:
   1) Assistance as needed to ensure that the immediate health care needs of the member are met; and
   2) A Quality of Care Resolution Letter (Attachment 2 at the end of this chapter) on the Regional Contractorôs letterhead is sent. The letter shall provide sufficient details to ensure all covered, medically necessary health care needs are met; contact name/title and telephone number to call for assistance or to express any unresolved concerns; the name, title and credentials of the person signing the letter; and if applicable, the Memberôs AHCCCS ID number.

I. Documenting closure of the review.

6. Additional actions by the Regional Contractors may be necessary, based on individual case circumstances, before a case is closed. These actions may include:
   A. Referring/reporting the issue to appropriate regulatory agencies such as Child or Adult Protective Services, AHCCCS, and/or CRSA for further research/review or action;
   B. Notifying the appropriate regulatory/licensing board or agency and CRSA when a health care professionalôs, organizational providerôs or other providerôs affiliation with their network is suspended or terminated because of quality of care issues; and
   C. Referral to the CRSA Peer Review Committee.

7. The Regional Contractor is responsible for tracking Quality of Care issues. Procedures for tracking and trending shall include:
   A. Contractors must ensure that member health records, as well as the records described in Chapter 60, Section 202, are available and accessible to authorized staff or their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care issues.
   B. The CRS Regional Contractor shall log and track all quality of care issues;
   C. The quality of care issues tracking log must be completed using

CRSA specified forms and/or databases. This includes:

1) interventions implemented to resolve and prevent similar incidences; and
2) resolutions status of ñsubstantiatedò, non-substantiatedò, and ñunable to substantiateò quality of care issues.

D. The logs and/or databases must be submitted to CRSA by the 15th of the month for the preceding month.

80.303 Credentialing and Re-credentialing Processes

This policy covers credentialing, temporary/provisional credentialing and re-credentialing policies for both individual and organizational providers.
Accreditation of the Contractor, specific to its line of business serving AHCCCS and CRS State Only members, by the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will demonstrate that credentialing and re-credentialing requirements have been met.

If the Contractor is not accredited as described above, the standards outlined in this Chapter must be demonstrated through the Contractor policies and procedures. Compliance will be assessed based on the Contractor policies and standards in effect at the time of the credentialing/re-credentialing decision.

Credentialing Individual Providers

The Regional Contractor must have a system supported by written policies and procedures or bylaws for credentialing and re-credentialing providers included in their contracted provider network that meet CRSA and AHCCCS requirements.

1. Credentialing and re-credentialing must be conducted and documented for at least the following contracted health care professionals:
   A. Physicians (MDs, DOs and DPMs);
   B. Nurse practitioners, physician assistants or certified nurse midwives providing primary care services, including prenatal and delivery services;
   C. Dentists;
   D. Psychologists; and
   E. Other certified behavioral health professionals who contract directly with the Contractor.
2. The Regional Contractor must ensure:
   A. The credentialing and re-credentialing processes do not discriminate against:
      1) A health care professional, solely on the basis of license or certification, or
      2) A health care professional who serves high-risk populations

or who specializes in the treatment of costly conditions.

B. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid.

3. If the Regional Contractor delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this chapter, it must retain the right to approve, suspend, or terminate any provider selected by that entity and must meet the requirements for delegation in 80.301 above. The CRS Regional Contractor remains responsible for delegated credentialing or re-credentialing decisions and shall maintain a credentialing committee in which the Regional Medical Director has final authority for CRS credentialing decisions. CRSA will maintain oversight responsibilities over the Regional Medical Director's CRS credentialing decisions.
4. Written policies must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policies and procedures must be reviewed and approved by the Regional Contractor's executive management, and:
   A. Reflect the direct responsibility of the Medical Director or other designated physician for the oversight of the process and delineate the role of the credentialing committee;
   B. Indicate the utilization of participating providers in making credentialing decisions; and
   C. Describe the methodology to be used by Contractor staff and the Contractor Medical Director to provide documentation that each credentialing or re-credentialing file was completed and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation.
5. Regional Contractors must maintain an individual credentialing/re-credentialing file for each credentialed provider. Each file must include:
   A. The initial credentialing and all subsequent re-credentialing applications;
   B. Information gained through credentialing and re-credentialing queries; and
   C. Any other pertinent information used in determining whether or not the provider met the Contractor's credentialing and re-credentialing standards.

Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of physicians and other licensed health care providers must include:

1. A written application to be completed, signed and dated by the provider that attests to the following elements:

A. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
B. Lack of present illegal drug use;
C. History of loss of license and/or felony convictions;
D. History of loss or limitation of privileges or disciplinary action;
E. Current malpractice insurance coverage; and
F. Attestation by the applicant of the correctness and completeness of the application.

2. Minimum five year work history
3. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification
4. Verification from primary sources of:
   A. Licensure or certification;
   B. Board certification, if applicable, or highest level of credentials attained;
   C. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training, if the Contractor lists physician schooling information in member materials or on their web site; and/or
   D. National Provider Databank (NPDB) query or, in lieu of the NPDB query, all of the following must be verified:
      1) Minimum five year history of professional liability claims resulting in a judgment or settlement, and
      2) Disciplinary status with regulatory board or agency, and
      3) Medicare/Medicaid sanctions.

Temporary/Provisional Credentialing

Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. The Contractor must follow the ñInitial Credentialingò guidelines 1 through 5 when granting temporary or provisional credentialing. The Contractor shall have 14 days from receipt of a complete application, accompanied by the minimum documents identified above, within which to render a decision regarding temporary or provisional credentialing.

The Contractor must follow the ñInitial Credentialingò guidelines 1 through 4 above to complete the credentialing process following the granting of temporary or provisional credentials.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
2. Lack of present illegal drug use;
3. History of loss of license and/or felony convictions;
4. History of loss or limitation of privileges or disciplinary action;
5. Current malpractice insurance coverage; and
6. Attestation by the applicant of the correctness and completeness of the application.

In addition, the applicant must furnish the following information:

1. Work history for past five years and
2. Current DEA or CDS certificate.

The Contractor must conduct primary verification of the following:

1. Licensure or certification;
2. Board certification, if applicable, or the highest level of credential attained; and
3. National Provider Data Bank (NPDB) query, or, in lieu of the NPDB query, all of the following:
    A. Minimum five year history of professional liability claims resulting in a judgment or settlement; and
    B. Disciplinary status with regulatory board or agency; and
    C. Medicare/Medicaid sanctions.

The Contractor Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this Section, should be completed.

Re-credentialing Individual Providers

At a minimum, the re-credentialing policies for physicians and other licensed health care providers must identify procedures that address the re-credentialing process and include requirements for:

1. Re-credentialing at least every three years;
2. An update of information obtained during the initial credentialing for sections (1) (except 1c), (3) and (4) (4 b) only requires update if provider is board certified); and
3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
    A. Medicare/Medicaid sanctions;
    B. State sanctions or limitations on licensure;
    C. Member concerns which include grievances (complaints) and appeals

information; and

D. Contractor Quality issues.

Credentialing Organizational Providers

For organizational providers included in its network (including hospitals, home health agencies, and free-standing surgi-centers):

1. Each Regional Contractor must validate, and re-validate at least every three years, that the organizational provider:
   A. Is licensed to operate in the State, and is in compliance with any other applicable State or Federal requirements, and
   B. Is reviewed and approved by an appropriate accrediting body or, if not accredited, Centers for Medicare and Medicaid Services (CMS) certification or State licensure review may substitute for accreditation. In this case, the Contractor must verify a review was conducted and compliance was achieved by obtaining a copy of the report.

CRSA Notification Requirement

The Regional Contractor must report to the CRSA Medical Director, who shall bring before the CRSA Peer Review Committee, upon discovery, any known serious issue and/or quality deficiency that could affect quality of care provided to CRS members.

80.400 Medical Management (MM)/Utilization Management (UM) Activities

80.401 Prior authorization

1. CRS Regional Contractors shall have a system for prior authorization including policies and procedure, coverage criteria, and processes for approval/denial of services.
2. CRS Regional Contractors shall have prior authorization staff that includes an Arizona-licensed nurse/nurse practitioner or physician with appropriate training to apply CRS medical criteria or make medical decisions. In addition, Contractors shall have a system for maintaining files/documentation in a secured location.
3. CRS Regional Contractors shall use a standardized criterion (InterQual) to make prior authorization decisions for medical necessity.
4. The CRS Regional Contractorsô prior authorization staff and CRS Regional Medical Director must attend Inter-rater Reliability Testing at least annually and as requested by CRSA. The CRS Regional Contractors shall have a process for additional education, training, and

monitoring of staff. New employees must attend the Inter-rater Reliability Testing within six months of hire.

5. The Regional Contractors shall provide prior authorization for the following services:
   - A. All non-emergent inpatient surgeries and medical admissions;
   - B. Purchase of durable medical equipment and customized adaptive aids (i.e., any orthotic, prosthetic, hearing aids, eye glasses, chest vests, or medical equipment, including custom modified wheelchairs);
   - C. Outpatient diagnostic tests (including MRIs) and laboratory services outside the CRS Regional Contractorôs existing sub-contractors;
   - D. Outpatient Positron Emission Tomography scans;
   - E. Non-emergent transportation services between CRS contracted hospitals/facilities;
   - F. All visits to be scheduled in a physician or dentist office;
   - G. Outpatient ambulatory surgery services;
   - H. Implantable bone conduction devices and tactile hearing aids; and
   - I. Non-formulary pharmacy requests.

6. Written policy and procedure for prior authorization shall include the following elements:
   - A. CRS Regional Contractors shall have a process to authorize services in a sufficient amount, duration, or scope and pay special attention to Balance Budget Act (BBA) required timelines for the standard and expedited review process: 14 calendar days for standard requests versus 3 working days for expedited requests; with an extension option of an additional 14 calendar days for both types of requests. Timelines shall be met even if the member has other third party liability insurance.
   - B. When a CRS Regional Contractor or provider determines/indicates that the standard response time could seriously jeopardize the memberôs life, health, or ability to maintain/regain maximum function, an expedited authorization decision is to be made within three working days following receipt of the request for service.
   - C. CRS Regional Contractors shall have a process for requesting an extension for up to 14 additional calendar days if either the member or provider requests the extension or the Regional Contractor justifies a need for additional information. The extension must be in the memberôs best interest.
   - D. Extensions initiated by the CRS Regional Contractor must be documented in writing to the member using the Notification of Extension of Service Authorization Timeframe (Attachment 6).
   - E. CRS Regional Contractors shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service.

F. On the day the timeframe expires, if a determination is not made then it is considered a denial.
G. The CRS Regional Contractor may consult with the requesting provider when appropriate.

7. CRS places the responsibility for obtaining prior authorization with the providers. The CRS Regional Contractors are responsible for verifying that the reviewing site is the proper CRS Regional Contractor to accept payment responsibility for the requested service.

8. The provider/physician is not guaranteed reimbursement with an authorization number. Documentation shall support the claim/service rendered.

9. The provider/physician shall complete a CRS Provider Services Requisition (PSR) form and transmit it to the CRS Regional Contractor Site where the service is to be provided.

10. Required Elements on Provider Services Requisitions (PSR) forms- A PSR form shall include (at a minimum) the following required elements:
A. CRS member name and date of birth;
B. Requesting physicianôs/providerôs name and specialty;
C. Requesting physicianôs license number;
D. Signature of the requesting physician/provider and date;
E. CRS diagnosis;
F. Proposed date of service;
G. Proposed service to be provided;
H. Narrative description or supporting documentation/reason of medical necessity for the proposed service;
I. Record date that PSR request is received by CRS Regional Contractor;
J. Type of authorization request (standard or expedited);
K. CRS eligibility checked;
L. Service covered by CRS;
M. Third Party Liability (TPL) insurance checked (if applicable);
N. Complete referral service category (inpatient, ambulatory, physicianôs office);
O. Name of surgeon and assistant surgeon (if applicable);
P. Place for signature of authorizing medical professional and date of prior authorization approval;
Q. Date authorization notice was sent to provider, physician, or facility;
R. Sent by ñstaff personôs nameò; and

S. Met timelines:
   1) Standard (14 calendar days)
   2) Expedited (3 working days)
   3) Extension (additional 14 calendar daysð final decision within 28 calendar days).

11. CRS Regional Contractor shall have a process for authorizing the Provider Service Requisitions that shall determine whether the requested services are medically necessary and appropriate. Decisions on CRS coverage and medical necessity shall be based on the criteria found in Chapters 30 and 40 of this manual.

12. CRS Regional Contractors shall investigate or verify other coverage(s) to which the individual may be entitled, including any requirements for pre-certification by other carriers or liable parties. However, the fact that the Contractor is the secondary payer does not negate the Contractorôs obligation to render a determination regarding coverage within the timeframes identified in Section 80.401, number 6.

13. CRS Regional Contractorsôprior authorization staff (RN, BSN, MD) shall sign and date the authorization for services and send notice of the authorization to the requesting provider when completed.

14. CRS Regional Contractors shall place appropriate limits on services based on a reasonable expectation that the amount of services authorized will achieve the expected outcome.

15. All CRS Regional Contractorsôprior authorization, concurrent, and retrospective decisions are subject to retrospective review by CRSA.

16. CRS Regional Contractors shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service.

17. CRS Regional Contractors shall have procedures for <u>denial</u> of services that include:
   A. A clinical review by the CRS Regional Medical Director of decisions to deny authorization on the grounds of medical appropriateness, medical necessity, or CRS coverage.
   B. The ability of the CRS Regional Medical Director to consult with another appropriately credentialed CRS physician(s) regarding the requested procedure when the requesting physician challenges the denial.

C. Notification of the requesting provider of any decision to deny, limit, or discontinue authorization of services including appropriate steps for appealing the decision.
D. Proper documentation regarding the reasons behind the adverse decision.
E. Adverse decisions shall only be rendered by the CRS Regional Medical Director, who must sign all denials (see Section 80.402).

80.402 Notice of Action, Notice of Service Authorization Extension, Notice to ALTCS/Acute Care Provider and Health Plan

1. The definition of an "Actionò is:
   A. The denial or limited authorization of a requested service, including the type or level of service;
   B. The reduction, suspension, or termination of a previously authorized service;
   C. The denial, in whole or in part, of payment for a service;
   D. The failure to provide a service in a timely manner, as set forth in contract;
   E. The failure of a contractor to act within the time frames required for standard and expedited resolution of appeals and standard disposition of grievances; or
   F. The denial of a rural CRS memberôs request to obtain services outside the CRS Regional Contractorôs network when the CRS Regional Contractor is the only Contractor in the rural area.

2. The CRS Regional Contractor must send a Notice of Action (Attachment 5) when:
   A. When a service requested by a provider is denied, reduced, or terminated.
   B. A request for a service from a member who the CRS Regional Contractor has the sole authority to approve or deny. (These are covered services that do not require a physician or qualified health care providerôs order.)

3. The CRS Regional Contractor is not required to issue a notice when:
   A. The CRS Regional Contractor issues a denial, reduction or termination of a service requested by a member for a service that requires a provider order. In these circumstances, it is expected that the Contractor timely refer the member to a provider.
   B. The Regional Contractor denies, reduces or terminates a memberôs request for a service which the provider has declined to order. A second opinion must be provided in accordance with the federal and state requirements.

4. Regardless of the category of authorization request, if a member requests further recourse when a denial or limited authorization of a requested service is given, a Notice of Action must be provided to the member.

Language and Format of the Notice of Action

1. The CRS Regional Contractor shall ensure that the Notice of Action is in writing and meets the following language and format requirements:
   A. The CRS Regional Contractors must use the approved Notice of Action form included at the end of this chapter. The Notice of Action form language and format shall not be altered aside from adding CRS Regional Contractor Letterhead, member identification information, and member specific information in the areas identified with the word ñ**INSERT."**
   B. The Notice of Action shall be available in each non-English language spoken by a significant number or percentage of members or potential members in the contractorôs geographic service area as established by contract. The Notice of Action shall explain that free oral interpretation services are available to explain the Notice of Action for all non-English languages.
   C. The Notice of Action must clearly explain at a fourth grade level the service being denied, reduced, or terminated and the reason for the action.

Content of the Notice of Action

1. The CRS Regional Contractor shall ensure that the Notice of Action explains the following:
   A. The action the CRS Regional Contractor has taken or intends to take;
   B. The reasons for the action including references to federal and state rules and regulations upon which the action is based;
   C. The memberôs right to file an appeal with the CRS Regional Contractor;
   D. The procedures for exercising the right to file an appeal;
   E. The circumstances under which an expedited resolution is available and how to request it; and
   F. The circumstances under which a member has a right to have services continue pending resolution of the appeal, how to request that services be continued, and the circumstances under which the member is liable for the costs of services.
2. The Notice of Action letter must be signed by the CRS Regional Contractor Medical Director.

General Requirements

1. The CRS Regional Contractor responsible for the action is responsible for providing the Notice of Action.
2. Timeframes for the Provision of the Notice of Action:
   A. When authorization for a requested service is denied, a Notice of Action shall be provided to the recipient as expeditiously as the health condition requires, but not later than:
      1) 14 calendar days for standard authorization denials; or
      2) Within 3 working days for expedited authorization decisions
      3) Authorization decisions may be extended for up to 14 days, as described in 80.401 above (Attachment 6).
   B. When continued authorization for a requested covered service is terminated, reduced or suspended, a Notice of Action shall be provided to the recipient at least 10 days prior to the date of the intended action, or at least 5 days prior to the date of the intended action in the case of suspected fraud. The CRS Regional Contractor may shorten the period of advance notice to 2 days before the date of intended action for the termination of non-emergency inpatient services, as a result of the denial of a continued stay request. A Notice of Action may be delivered on the date of action under the following circumstances:
      1) Death of recipient;
      2) Written statement by recipient that services are no longer wanted;
      3) Recipient is age 21-64 and in an IMD for over 30 days;
      4) Recipient is an inmate of a public institution not receiving federal financial participation;
      5) Whereabouts of recipient are unknown and post office returns mail indicating no forwarding address; or
      6) Acceptance into another State's Medicaid Program.
   C. Delivery of the Notice of Action
      The Notice of Action must be:
      1) Sent to the Member or their legal or authorized representative, and copied to the ALTCS/Acute Care Contractor and/or the requesting provider, as appropriate.
      2) A copy of the Notice of Action must be retained in the clinic record.

Notices to an ALTCS/Acute Care Contractor

1. Requests received by an ALTCS/Acute Care Contractor for a service to a CRS recipient:
   A. The ALTCS/Acute Care Contractor shall conduct a review of the

request for medical necessity.

B. If the ALTCS/Acute Care Contractor believes the service is not medically necessary, the ALTCS/Acute Care Contractor shall contact a CRS Regional Medical Director for a second opinion to determine whether CRS concurs with the ALTCS/Acute Care Contractorôs determination. CRS shall determine whether the requested service is medically necessary and shall respond to the ALTCS/Acute Care Contractor within 1 working day. The entire process shall occur with the standard authorization timeframe of 14 days.

C. If the CRS Regional Medical Director concurs that the service is not medically necessary, the ALTCS/Acute Care Contractor shall deny the request and send a Notice of Action to the member.

D. If the CRS Regional Medical Director determines that the service is medically necessary, CRS and the ALTCS/Acute Care Contractor shall follow the process in 1.F.1 & 2.

E. If the ALTCS/Acute Care Contractor determines the service is medically necessary and believes that the service is a CRS covered benefit, the ALTCS/Acute Care Contractor shall:
   1) Notify CRS of the request; and
   2) Simultaneously inform the member that a 14-day extension is being taken (a decision must be rendered no later than 28 days from the date the request was initiated) to provide the decision to the member and provider.

F. CRS shall review the request:
   1) If CRS approves the services:
      a) It will notify the ALTCS/Acute Care Contractor.
      b) The ALTCS/Acute Care Contractor shall notify the member in writing that the service will be provided by CRS and direct the member to CRS.
      c) The ALTCS/Acute Care Contractor shall assist the member in contacting CRS.
   2) If CRS denies the services:
      a) It will send **no** notice to the member.
      b) It will notify the ALTCS/Acute Care Contractor in writing of its decision (Attachment 7).
      c) The notification shall also inform the Medical Director of the ALTCS/Acute Care Contractor of the right to appeal the decision by filing a Request for Review in writing with the CRS Regional Medical Director no later than 10 business days after the decision.
      d) The ALTCS/Acute Care Contractor will:
         i) Process the request within the 28-day

timeframe of the original request.

ii) Provide requested services as ordered, or provide limited authorization of the request. If limited authorization is provided, the Contractor shall issue a Notice of Action to the member.

e) Upon receipt of the Request for Review by CRS:

i) The CRS Regional Medical Director shall issue a written decision to the ALTCS/Acute Care Contractor no later than ten (10) business days from the date of the receipt of the Request for Review (Attachment 8).

ii) The CRS decision shall advise the ALTCS/Acute Care Contractor Medical Director that the ALTCS/Acute Care Contractor may file a request for hearing with the AHCCCS Administration within thirty (30) days of receipt of the CRS decision in the event that the ALTCS/Acute Care Contractor disagrees with the CRS decision.

f) If the AHCCCS Hearing Decision determines that the service should have been provided by CRS, CRSA shall be financially responsible for the costs incurred by the ALTCS/Acute Care Contractor in providing the service.

g) The timing of the above steps shall be as follows:

i) Day 1 (day request is received) through Day 5 - ALTCS/Acute Care Contractor review, if not a CRSA covered benefit and approve or deny the request;

ii) Day 6 - Fax to CRS with medical documentation to support the request;

iii) Day 7 through Day 15 - CRS review;

iv) Day 16 - CRS to fax or call the ALTCS/Acute Care Contractor with the decision. If CRS denies the request, CRS proceeds as in III, (D)(4). If CRS authorizes the service, CRS and the ALTCS/Acute Care Contractor proceeds as in Section III, (D)(3); and,

v) Day 17 through Day 28 ï If CRS denies the request, ALTCS/Acute Care

Contractor authorizes the service. If the ALTCS/Acute Care Contractor provides limited authorization of the request, issues a Notice of Action. ALTCS/Acute Care Contractor may follow the Request for Review guidelines. [Refer to the process in V, E, 5, b, 3).]

h) The ALTCS/Acute Care Contractor is responsible for rendering the decision no later than the total 28-day timeframe beginning when the date request is received. If CRS fails to issue an authorization decision within the above timeframe, the ALTCS/Acute Care Contractor shall authorize the request and provide the service. Then, the ALTCS/Acute Care Contractor may file a request for hearing with the AHCCCS Administration within 30 days from the date the authorization decision should have been issued by CRS.

2. Request received by an ALTCS/Acute Care Contractor for a member who is not enrolled with CRS.

A. If the Contractor reasonably believes that the member has a CRS condition and the service is related to that condition, the Contractor shall:

1) For urgent requests:

i) Initiate a Medical Director to Medical Director communication for urgent requests.

ii) If the request meets medical necessity guidelines and is date sensitive, the ALTCS/Acute Care Contractor must review and follow medical guidelines to assure that medically necessary care is not delayed.

2) For non-urgent requests:

i) The ALTCS/Acute Care Contractor shall refer the member to CRS.

ii) The ALTCS/Acute Care Contractor shall issue a Notice of Action to the member denying the service referencing that CRSA may be the responsible entity for the service and that the member must establish eligibility with CRSA.

iii) The ALTCS/Acute Care Contractor shall assist the member in contacting CRS as necessary. (Refer to the process as a Request for Review.)

iv) The ALTCS/Acute Care Contractor will monitor the CRSA application to ensure that the process is

completed by the member's legal guardian.

v) The ALTCS/Acute Care Contractor will monitor the CRSA application outcomes in order to ensure ordered medically necessary care is provided.

vi) In the event that CRS determines that the member does not meet the medical eligibility requirement for participating in the CRS program, CRS shall inform the referring physician and the applicable ALTCS/Acute Care Contractor, in writing, of the denial and the reason for the denial within 5 working days of the denial.

3. Request received by CRS for AHCCCS members who are CRS recipients

A. CRS shall determine if the request is a CRS covered benefit.

B. If CRS determines the request is not a CRS covered benefit:

1) CRS will send no notice to the member, but shall notify the ALTCS/Acute Care Contractor in writing (Attachment 9).

2) Simultaneously, CRS shall inform the member in writing that:

i) A 14-day extension is being taken (not to exceed 28 days) (Attachment 10);

ii) The service request is not a CRS covered benefit; and,

iii) That the request is being referred to the member's primary AHCCCS plan.

3) CRS shall direct the member to the ALTCS/Acute Care Contractor.

4) CRS shall assist the member in contacting the ALTCS/Acute Care Contractor.

C. ALTCS/Acute Care Contractor shall review the request and:

1) Shall conduct a review of the request for medical necessity.

i) If the ALTCS/Acute Care Contractor determines that the service is not medically necessary, the Contractor shall deny the request and send a Notice of Action to the member and notify CRS of its decision.

ii) If the request is determined medically necessary and is not a CRS covered benefit, the Contractor shall authorize the service and notify CRS in writing of its decision.

iii) If the request is determined medically necessary and is presumed to be a CRS covered benefit, the ALTCS/Acute Care Contractor shall authorize the

service and may file a request for hearing with the AHCCCS Administration within thirty (30) days of receipt of the CRS decision.

2) The timing of the above steps shall be as follows:
   i) Day 1 (day request is received) through Day 5 ï CRS review;
   ii) Day 6 ï Fax to ALTCS/Acute Care Contractor with medical documentation to support request;
   iii) Day 7 through Day 15 ï ALTCS/Acute Care Contractor review for medical necessity; and,
   iv) Day 18 through 28 ï ALTCS/Acute Care Contractor authorizes the services or issues a Notice of Action to the member when a requested service is denied or a limited authorization is given.

80.403 Concurrent Review

1. CRS Regional Contractors shall have a system of utilization review for a memberôs hospital admission and hospital stay. The CRS Regional Contractor Medical Director oversees this process.

2. CRS Regional Contractors shall have procedures for review of medical necessity prior to a planned institutional admission (prior authorization) and for determination of the medical necessity for ongoing institutional care (concurrent review) using standard criteria (InterQualsô Level of Care Criteria).

3. CRS Regional Contractors shall have adequate, qualified, and professional medical staff (i.e., physician, physician assistant, nurse practitioner, and/or RN/BSN) to conduct reviews.

4. The CRS Regional Contractorsô shall have policies and procedures that contain the following elements for the concurrent review process:
   A. CRS Regional Contractors shall have a process to ensure that the medical necessity review must include what relevant clinical information is to be obtained when making hospital length of stay decisions such as diagnosis, required services, diagnostic test results, and symptoms.
   B. CRS Regional Contractors shall ensure consistent application of review criteria and compatible decisions that include Inter-rater Reliability criterion and monitoring of all staff involved in the concurrent review process, including the CRS Regional Medical Director.

C. CRS Regional Contractors shall ensure that all previously (prior) authorized stays will have a specific date by which the need for continued stay would be reviewed.

D. Reviews of an admission not prior authorized will be conducted within 1 business day after notification. The extension of a continued stay shall be assigned a new review date each time a concurrent review occurs.

E. Decisions on coverage and medical necessity must be clearly documented.

F. CRS Regional Contractors shall ensure that they have a process for review by another qualified physician in the event an ordering physician challenges a length of stay or level of care determination or decision of medical necessity.

G. CRS Regional Contractors concurrent review staff shall have a process in place to communicate with the CRS Regional Medical Director when a CRS member is found ineligible for a particular service or set of services.

H. CRS Regional Contractorôs utilization review staff shall coordinate with the hospital/facilityôs Utilization Review Department and Business Office regarding any change in authorization status.

I. All denials for continued services shall be signed by the CRS Regional Contractor Medical Director.

J. Written notification of a denial of hospital days or services for a CRS member shall be sent to the CRS attending physician and all representative parties, including the insurance carrier, parent, or guardian, within 24 hours prior to date of discontinued coverage.

5. All CRS Regional Contractor prior authorization, concurrent, and retrospective decisions are subject to retrospective review by CRSA.

80.404 Decertification of a Hospital Stay

1. CRS Regional Contractors shall have a system in place to manage CRS care and monitor the appropriateness of services. The CRS Regional Contractor Medical Director oversees this process.

2. All elective and urgent hospital/ambulatory admissions are reviewed by the CRS Regional Contractorôs authorization department. If, during the course of hospitalization, the CRS member is determined by the concurrent review nurse to be potentially medically ineligible or is potentially ineligible for a particular service or set of services, the following will occur:

A. CRS Regional Contractorôs utilization review staff will review the pertinent information/medical record with the CRS Regional Medical

Director or designee;

B. If the CRS Regional Contractorôs Medical Director makes the denial, the authorization status will reflect decertification of continued hospital days or services;

C. CRS Regional Contractors Medical Director shall sign all denial, reduction, or modification of services;

D. CRS Regional Contractorôs utilization review staff will coordinate with the contracting hospitalôs Utilization Review Department and Business Office regarding any change in authorization status; and

E. Written notification of a denial of hospital days or services for a CRS member (decertification) shall be sent to the CRS attending physician and all responsible parties, including the insurance carrier and parent or guardian, within 24 hours prior to the date of discontinued coverage; however, no notice of action shall be sent to AHCCCS members/families. Please refer to Section 80.402 for appeals process.

F. CRS Regional Contractors will not be financially responsible for hospitalization and/or the physician component of care after the date of the denial.

80.405 Retrospective Review

1. CRS Regional Contractors shall have a system for retrospective review including policies and procedures, coverage criteria, and processes for approval/denial of services.

2. CRS Regional Contractors shall have qualified staff that includes an Arizona licensed nurse/nurse practitioner or physician with appropriate training to apply CRS medical criteria or make medical decisions. In addition, Contractors shall have a system for maintaining files/documentation in a secured location.

3. CRS Regional Contractors shall use a standardized criterion (InterQual) to make retrospective review decisions for medical necessity.

4. The CRS Regional Contractorôs retrospective review staff and CRS Regional Medical Director must attend Inter-rater Reliability Testing at least annually and as requested by CRSA. The CRS Regional Contractor shall have a process for additional education, training, and monitoring of staff. New employees must attend the Inter-rater Reliability Testing within six months of hire.

5. CRS Regional Contractors must complete retrospective reviews for all emergency services. A Retrospective Review form containing all the

essential elements to determine medical necessity for the emergency service(s) shall be utilized.

6. Retrospective Reviewð Required Elements:
   A. Review was conducted by a qualified and professional medical staff;
   B. A standard form was used for the review;
   C. Dates are clearly specified to ensure timelines were met (e.g., date service was provided, date CRS was notified, and the date of the retrospective review);
   D. Determination of necessity of emergency service setting;
   E. CRS eligible diagnosis was relevant to emergency services;
   F. Services met the memberôs needs; and
   G. Decisions on coverage and medical necessity are clearly documented.

7. The timeframes for Retrospective Reviews shall not exceed 28 days from date of receipt of notification.
8. All CRS Regional Contractor prior authorization, concurrent, and retrospective decisions are subject to retrospective review by CRSA.

80.406 Drug Utilization Patterns

The purpose of Drug Utilization Review (DUR) is to assure the clinically appropriate, safe, and cost effective use of drug therapy to improve health status and quality of care. CRS Regional Contractors must develop policies and procedures that include prospective review processes for:

1. All drugs before dispensing. This process may be accomplished at the pharmacy using a computerized DUR system; and
2. All non-formulary drug requests.

80.407 Case Management/Care Coordination

1. Contractors must establish a process to ensure coordination of care for members that includes:
   A. Coordination of CRS health care through a multi-specialty, interdisciplinary treatment plan; and
   B. Collaboration with providers, communities, agencies, service systems, members, and families; and
   C. Consultation reports sent to the referring physician and appropriate health plan within 30 days of the first visit to include:
      1) Plan of care;
      2) Diagnosis; and
      3) Name, address and phone number of the CRS provider.

D. CRS shall provide service coordination, communication, and support services designed to manage the transition of care for a member who requires temporary care within an alternative delivery system, or who no longer meets CRS eligibility requirements.

2. Information regarding CRS services shall be shared in a timely manner with all other appropriate professionals, with the member's or family's consent, through discharge planning activities, interdisciplinary team meetings, and service coordination activities.
3. CRS shall also notify an AHCCCS member's health plan/program contractor of the member's discharge when appropriate for care coordination.

80.408 Facility Transfers (For more detail, please refer to Chapter 40, Section 40.901, "Transfer of Care"

1. CRS Regional Contractors may authorize facility transfers for CRS members only under the following conditions:
   A. The transfer occurs between CRS contracted facilities;
   B. The transfer is for the treatment of a CRS condition;
   C. The transfer or transport is ordered and approved by a CRS Regional Contractor's provider; and
   D. The transfer or transport is reviewed in advance and authorized by the CRS Regional Medical Director.
2. The transferring agency must complete applications for transfers in writing and shall include all diagnostic information regarding the CRS condition. The CRS Regional Contractor Medical Director or designee reviews the documentation to support the transfer, along with other consultation disclosures, and approves or denies the request for the transfer.
3. A transfer must be completed within forty-five (45) days. The CRS Regional Contractor's performance will be measured based on a minimum acceptable performance of 75% in the first year and 85% for the subsequent year, with a goal of 90%.
4. If a transfer is approved, and it is subsequently determined that the transferring agency failed to provide complete or accurate information about the member's condition, which resulted in a transfer of a member to treat an ineligible condition, CRS may transfer the member back to the originating facility at the expense of the original transferring agency.
5. When completing facility transfers, a member does not need to undergo the entire eligibility determination process again. No initial medical evaluation or eligibility/financial appointment is necessary as long as the member was still enrolled with the transferring site at the time of the transfer. An appointment shall be conducted to review the plan for treatment at the receiving site.

80.409 Transition of Care

CRS Regional Contractors shall have a system for transition of care to ensure compliance with continuity of care for all CRS members.

1. Pediatric to Adult Transition:
   For CRS member's who are transitioning to adult services, the CRS Regional Contractor shall initiate a transition plan by age fourteen (14) which is ongoing until the member leaves the CRS program.
   The transition plan shall:
   A. Establish a timeline for completing all services the member should receive through CRS prior to his or her twenty-first birthday;
   B. Advise the memberôs primary care provider of the discharge and ensure coordination of the services with the adult primary care provider;
   C. Ensure families, members, and their primary care providers are part of the development and implementation of the transition plan;
   D. Document the transition plan in the medical record;
   E. Coordinate the transition plan with the appropriate:
      1) AHCCCS health plan;
      2) ALTCS program contractors;
      3) IHS/638 and tribal entities upon discharge from a CRS clinic and/or discharge from the CRS program; and
      4) Private insurance.

2. Members aging out of the CRS system:
   A. CRS Regional Contractors shall have a system for transition of care to ensure compliance for continuity of care for members aging out of the CRS system;
   B. The CRS Regional Contractor shall notify the memberôs primary health care provider/AHCCCS Contractor in writing sixty (60) days prior to the memberôs 21st birthday to ensure continuity of care. CRS is not financially responsible for an AHCCCS member on or after his/her 21st birthday.
   C. CRS Regional Contractors shall ensure that an ETI (Enrollment Transition Information) Form (AHCCCS Exhibit 520-2, available at http://www.ahcccs.state.az.us/Regulations/OSPpolicy/chap500/Chap500.pdf), is completed for all CRS enrolled members sixty (60) days prior to their 21st birthday and placed in the medical record;
   D. CRS Regional Contractors shall submit a copy of all ETI forms to the CRSA MM/UM Program on a monthly basis;
   E. The CRS Regional Contractors compliance for continuity of care for member(s) aging out of the CRS system shall be evaluated monthly by a CRSA UM Specialist.

80.410 Referral Management

The CRS Regional Contractor will have a policy and procedure for referral of members for specialized care. Examples of referrals include: out of state referrals, second opinions, referrals from one CRS clinic specialist to another, health plan referrals, referrals from primary care providers to CRS clinics, and intersite transfers.

80.411 Adoption and Dissemination of Practice Guidelines

Contractors must develop a process to ensure practice guidelines are disseminated by the Contractor to all affected providers and, upon request, to member's and potential members.

80.412 New Medical Technologies and New Uses of Existing Technologies

CRS Regional Contractors may initiate a request for CRS coverage for new medical technologies and submit the proposal to the CRSA Medical Director for review. The proposal must include medical necessity criteria, supporting documentation, and a cost analysis for the new medical technology.

CRS Regional Contractors shall participate in the review of new medical technologies and new uses of existing technologies through the CRSA/CRS Medical Directors Meeting.

CRSA shall review the requests and respond in a timely manner to the Regional Contractors on the decision for coverage by the CRS Program.

80.413 Discharge Planning

1. The CRS Regional Contractor shall have policies and procedures that address discharge planning that include:
   A. Inpatient discharge planning;
   B. Pediatric to adult transition planning; and
   C. Discharge planning for members exiting the CRS program.
2. For CRS members receiving inpatient services, the CRS Regional Contractor shall:
   A. Initiate discharge planning upon the member's hospital admission;
   B. Include coordination with all agencies responsible for post-hospital care (e.g., CRS, DES/DDD, AHCCCS, ALTCS, DES/CMDP and DES Adoption Subsidy); and
   C. Transfer and decertify CRS authorized admissions for the CRS members in accordance with the specific ADHS/CRS policy.
3. For CRS members exiting the CRS system and/or CRS members who are

transitioning to adult services, refer to Section 80.409.

4. For CRS members aging out of the CRS system, refer to Section 80.409.

80.414 Specialty Referral Timeline

1. The CRS Regional Contractor shall have a policy and procedure that ensures adequate access to care through scheduling of appointments to specialists within 45 days of the date of a referral request. For urgent requests the timeframe for an appointment is 72 hours.

2. The CRS Regional Contractor shall maintain and provide to CRSA a detailed list of their providers and their specialties and will submit monthly reports of requests for referrals to specialists. If AHCCCS health plans are required to render any CRS-covered service due to the CRS Regional Contractorsô failure to meet medically necessary appointment standards, the CRS Regional Contractor shall be financially responsible for those services.

3. The Contractor shall be subject to sanction for failure to meet appointment standards.

80.415 Telephonic Response Standards

Regional Contractors shall have sufficient staff and policies and procedures to handle phone calls from members and applicants promptly and appropriately.

80.500 Other Program Activities

80.501 New Member Orientation Packet

1. CRS Regional Contractors must, on an annual basis, inform all members of their right to request at a minimum:
   A. An updated CRS Member Handbook; and
   B. An updated comprehensive directory of the CRS Regional Contractorôs Clinic Providers.
2. CRSA shall provide the Regional Contractors with a current CRS Member Handbook.
3. The CRS Regional Contractors shall:
   A. Develop, distribute and maintain a New Member Orientation Packet;
   B. Have New Member Orientation Packets available to all new members at the time of their initial appointment; and
   C. Submit the New Member Orientation Packets annually to CRSA for review and approval.
4. New Member Orientation Packets must:
   A. Contain a current CRS Member Handbook;
   B. Contain a comprehensive directory of the CRS Regional

Contractor's Clinic Providers, which includes:
1) Specialty clinic providers' names;
2) Specialty clinic telephone numbers;
3) Non-English languages spoken by the providers;
4) If any revisions, the date of last revision;
5) Any restrictions or an explanation of the member's freedom of choice among clinic providers;
6) A reference to the contractor's website for a complete listing of all its network providers.

C. Be printed in a type, style and size that can be easily read by recipients with varying degrees of visual impairment and meet the ADA regulations;
D. Be written at a 4th grade reading level;
E. Have a date of the last update of the materials included;
F. Provide written notification that alternate formats are available and how to access them;
G. Provide written notification that oral interpreter services are available free of charge upon request; and inform potential enrollees and members on how to access those services;
H. Contain information on the following:
1) The Regional Contractor's CRS Parent Action Council;
2) Family and parent organizations and other appropriate resources including community service agencies.

80.502 Provider Manual

1. CRS Regional Contractors shall:
A. Develop and maintain a Provider Manual;
B. Have Provider Manuals available to all contracted providers;
C. Submit the Provider Manuals annually to ADHS/CRSA for review and approval.
2. Provider Manuals must:
A. Be organized and in a style that is easy to follow;
B. Contain current information;
C. Contain a signature of the CRS Regional Contractor Administrator indicating their review and approval of the manual;
D. Have a date of the last update;
E. At a minimum include:
1) An introduction to the CRS Regional Contractor explaining its organization and administrative structure;
2) The providers' responsibility and the CRS Regional Contractor's expectations of the providers to include their role in quality and utilization management initiatives;
3) An overview of the CRS Regional Contractor's Provider

Service department and function;

4) A listing and description of covered and non-covered services, requirements and limitations;
5) Emergency Room utilization (appropriate and non-appropriate use of the emergency room);
6) Dental services;
7) Referrals to specialists and other providers to include, when applicable, coordination of services with AHCCCS Health Plans/ALTCS Plans and their providers;
8) A listing of enrollee rights and responsibilities as outlined by CRSA with a notation that the providers must provide care in accordance with these rights;
9) A statement that the provider is not restricted from advising or advocating on behalf of an enrollee who is his/her patient for the following:
    a) The enrolleeôs health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
    b) Any information the enrollee needs in order to decide among all relevant treatment options;
    c) The risks, benefits, and consequences of treatment or non-treatment; and
    d) The enrolleeôs right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
10) A statement notifying the providers that with the enrolleeôs written consent, they have the right to act on behalf of the enrollee and file an appeal;
11) Copies of any CRS Practice Guidelines;
12) Copy of the CRSA Peer Review Policy;
13) Claims disputes and hearing rights;
14) Billing and encounter submission information;
15) An indication of the form, UB92, HCFA 1500, or Form C that is to be issued for services;
16) An indication of the fields required for a claim to be considered acceptable by the CRS Regional Contractor;
17) Completed samples of UB92, HCFA 1500, or Form C;
18) CRS Regional Contractorôs written policies and procedures which affect the provider(s) and/or the provider network including:
    a) Claims re-submission policy and procedure;
    b) An explanation of remittance advice;
    b) Prior authorization requirements;

c) Claims medical review;
d) Concurrent review;
e) Fraud and Abuse;
f) How to access formularies; and
g) ADHS/CRSA appointment standards.

19) Information on how to obtain educational materials and to access interpretation and translation services for members who have Limited English Proficiency (LEP) or prefer to speak a language other than English, or who use Braille or sign language;
20) Americans with Disabilities Act (ADA) requirements when providing services outside the CRS Regional Clinic setting;
21) A statement that providers are required to provide members with information regarding their health care including available treatment options and alternatives in a manner appropriate to the memberôs condition and ability to understand;
22) A statement that providers must allow members to participate in decisions regarding their health care, including the right to refuse treatment;
23) A statement that providers are required to assist members with Limited-English Proficiency (LEP) at all points of contact including providing sufficient access to interpreters and ensuring the qualifications of bilingual staff;
24) A statement that providers and staff are to treat all members with respect, dignity, and consideration for privacy;
25) A statement that in the process of coordinating care, each memberôs privacy is protected in accordance with privacy requirements;
26) A statement that medical records and any other health and enrollment information that identifies a particular member must be confidential, according to requirements of HIPAA;
27) Providers need to ensure that members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
28) CRS memberôs have the right to obtain a second opinion free of charge from an appropriately qualified health care professional and providers may need to assist the member with a referral to the Contractor;
29) The member must be free to exercise his/her rights, without adversely affecting the way the providers and their staff treat the member;
30) Providers are to provide information on advance directives to adults (18 years and older) and to acknowledge the

member's rights under the law of the State to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

31) Providers must document in the medical record whether or not the individual has executed an advance directive and must not contain the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
32) Providers have the right to file a grievance (complaint, expression of dissatisfaction) with the Contractor. A provider, acting on behalf of the member with the member's written consent, may file an appeal. A provider may file a grievance or request a State Administrative Hearing on behalf of the member;
33) Providers have the right to file an appeal of a medical service denial, suspension, or reduction on behalf of a member with the member's written consent;
34) Providers have been given specific information about timelines for filing an appeal;
35) Upon request of a member, the provider must provide them with a copy of the member's medical records and respond to a request that may be amended or corrected; and
36) Provide cultural competency information, notification about Title VI of the Civil Rights Act of 1964, Culturally Linguistically Appropriate Services (CLAS) standards and Limited English Proficiency (LEP). Providers should also be informed of how to access interpretation and translation services to assist recipients who are LEP and speak a language other than English or who use sign language.

80.503 Policy and Procedure Manuals

1. Each CRS Regional Contractor shall develop and maintain a Policy and Procedure manual that includes the processes for carrying out the requirements of the RCPPM. Each policy must contain the following:
   A. A clear title;
   B. Contain a signature of the CRS Regional Contractor Administrator indicating their review and approval of the policy and/or procedure;
   C. The original date of the policy;
   D. The last date the policy or procedure was updated;
   E. The last date the policy or procedure was reviewed;
   F. Content that is complete and concise; and
   G. A process for continuous review of personnel and subcontractor

performance.

2. CRS Regional Contractorsô Policies and Procedures must be reviewed at least annually, and updated as needed to reflect changes in the RCPPM.
3. CRS Regional Contractors must maintain updated copies of the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM).

80.504 Contract Monitoring

ADHS and any other appropriate agent of the State or Federal Government, or any of their duly authorized representatives, shall have access during reasonable hours to the Regional Contractor's facilities and the right to examine the contractor's books, documents, and records involving transactions related to their contract with ADHS/CRS.

80.600 Provider Network Development and Management

CRS Regional Contractors must:

1. Maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
2. Not discriminate with respect to participation in the CRS program, reimbursement, or indemnification against any provider based solely on the providerôs type of licensure or certification.
3. Give the affected providers written notice of the reason for its decision, if a Regional Contractor declines to include individual or groups of providers in its network. CRS Regional Contractors may not include providers excluded from participation in Federal health care programs.
4. Have policies and procedures in place that pertain to all service specifications specifying how they will:
   A. Communicate with the CRS network regarding contractual and/or program changes and requirements;
   B. Notify affected members within 15 days of CRS acquiring knowledge that a provider is leaving the network [42 C.F.R. § 438.10(f)(5)];
   C. Notify affected members of material program changes at least 30 days prior to the effective date of the change [42 C.F.R. § 438.10(f)(4)];
   D. Monitor and ensure network compliance with policies and rules of AHCCCSA and CRSA;
   E. Evaluate the quality of services delivered by the network;
   F. Provide or arrange for medically necessary covered services should the CRS network become temporarily insufficient;

G. Monitor network capacity to ensure that there are sufficient providers to handle the volume and needs of CRS recipients. This includes staff and other resources to handle the language needs involved in the provision of care to CRS recipients with Limited English Proficiency; and
H. Ensure service accessibility, including monitoring appointment standards, and appointment waiting times.

5. Participate in the development, implementation and updating of the Statewide CRS Provider Network Plan as requested by CRSA to ensure that pediatric specialty care is provided in the most effective manner to all CRS members throughout the state.

All material changes in the CRS provider network must be approved in advance by CRSA. A material change is defined as any change in overall business practice that could have an impact on 5% or more of the recipients, providers, or AHCCCS programs, or may significantly impact the delivery of services provided by the CRS Regional Contractor. CRSA must be notified of planned material changes in the provider network before the change process has begun, for example, before issuing a 60-day termination notice to a provider.

The Regional Contractor shall notify CRSA in writing within one (1) business day of any unexpected changes to its provider network. This notification shall include:
1. Information about how the change will affect the delivery of covered services;
2. The Regional Contractor plans for maintaining the quality of recipient care if the provider network change is likely to result in deficient delivery of covered services; and
3. The Regional Contractorsô plan to address and resolve any network deficiencies.

CRS Regional Contractors must notify providers and recipients in writing thirty (30) calendar days prior to the effective date of a program change or any other change in the network, excluding a provider leaving the network. The notification letter must be submitted to CRSA forty-five (45) calendar days prior to the effective date of the change for review and approval [42 CFR 438.10(f)(4)].

Within thirty (30) days of the CRS Regional Contractor communicating a change to the CRS network and/or members, CRS Regional Contractors must provide CRSA with evidence of how the communication with the CRS network and/or members was completed, such as provider/member newsletters, postings on the website, etc.

80.700 Request for Extension of Submission Deadline and Sanctions

80.701 Request for Extension of Submission Deadline

The CRS Regional Contractor shall request approval for an extension for report submission. The requirement to request approval for an extension applies to all reports due to CRSA (financial reporting and quality assurance reporting).

As soon as a CRS Regional Contractor is aware that they will not be able to submit a report by the required due date (but at least 10 working days prior to the due date) the CRS Regional Contractor must request in writing an approval for an extension. For due dates of reports please refer to your contract (Appendix G-1). The written request for extension for report submission should include the circumstances requiring the extension request and the requested timeframe for the extension.

80.702 Sanctions

CRSA may impose financial sanctions on contractors for failure to perform as required, failure to submit timely and accurate reports, engaging in actions that jeopardize Federal Financial Participation, AHCCCS imposed sanctions on CRSA for action by the CRS Regional Contractors (e.g., pended encounter sanctions), or any other breach of the terms of this contract. Other sanctions may be imposed against the contractors and their service providers in accordance with defined CRSA policies.

Sanctions may be imposed for, but not limited to, the following actions:

1. Substantial failure to provide medically necessary services that CRSA is required to provide under the terms of this contract;
2. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver;
3. Discrimination among CRS recipients on the basis of their health status of need for health care services;
4. Misrepresentation or falsification of information furnished to CMS or AHCCCSA or CRS;
5. Misrepresentation or falsification of information furnished to a recipient, potential recipient, or provider;
6. Failure to meet AHCCCS Financial Viability Standards;
7. Material deficiencies in CRS provider network;
8. Failure to meet quality of care and quality management requirements;
9. Failure to meet AHCCCS/CRS encounter standards;
10. Violation of other applicable State or Federal laws or regulations;
11. Failure to require subcontractors to increase the Performance Bond in a timely manner;
12. Failure to comply with any provisions contained in the contract;

13. Failure to report third party liability cases; or
14. Failure to meet contractual reporting requirements.

CRSA may impose the following types of sanctions:
1. Civil monetary penalties;
2. Appointment of temporary management for CRS Regional Contractors as provided in 42 CFR 438.706 and A.R.S. §36-2903 (M);
3. Suspension of payment for recipients after the effective date of the sanction until CRSA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or
4. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

The financial sanction process applies to all required reports that have not been granted an extension. For due dates of reports please refer to your contract (Appendix G-1). Required reports submitted must be substantially complete and correct.

If the report is not submitted within the thirty (30) day grace period, a sanction of $500 per day will be levied until the report is received.

A second offence of an untimely submitted report of the same nature will not receive the thirty (30) day grace period. Sanctions will begin the day following the due date.

80.800 Corporate Compliance Program

1. Each Regional Contractor shall have a Corporate Compliance Program, supported by a written plan. The plan shall include all seven elements required in 42 CFR 438.608. The seven elements are:
   A. Written policies, procedures, and standards of conduct that articulate the organizationôs commitment to comply with all applicable Federal and State standards;
   B. The designation of a compliance officer and a compliance committee that are accountable to senior management;
   C. Effective training and education for the compliance officer and an organizationôs employees;
   D. Effective lines of communication between the compliance officer and the organizationôs employees;
   E. Enforcement of standards through well-publicized disciplinary guidelines;
   F. Provision for internal monitoring and auditing;

G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the CRSA contract.

The plan should also contain:

A. Standards of conduct, procedures, internal controls, and system edits for the prevention and detection of fraud and abuse and compliance with federal and state requirements for the following areas of responsibility:
   1) Claims processing;
   2) Prior authorization, concurrent review and other utilization management activities;
   3) Quality management;
   4) Clinic services;
   5) Medical eligibility determinations;
   6) Financial category determinations;
   7) Encounter submissions;
   8) Financial reporting;
   9) Provider credentialing;
   10) Subcontracted services; and
   11) Provision for internal monitoring and auditing.

B. Provision for ensuring the reporting of suspected fraud or abuse within ten (10) days of discovery directly to:
   1) AHCCCSA (Office of Program Integrity) for situations involving Title XIX/Title XXI members, providers and/or funding using the AHCCCS Referral for Preliminary Investigation found on the AHCCCSA web site, with a copy to the CRSA Compliance Officer and
   2) The ADHS Compliance Officer for State only issues using the form on the ADHS web site.

C. Provision for ensuring compliance with 42 CFR § 438.610 related to prohibited affiliations with individuals debarred by Federal agencies.

D. Provision for ensuring compliance with Public Law 109-171, Section 1902(a) of the Social Security Act, 42, U.S.C., § 1396a related to employee education about false claims recovery.

2. Each Regional Contractor shall have a CRS Compliance Officer who reports directly to the CRS Regional Administrator and/or to the parent organizationôs Corporate Compliance Officer and whose responsibilities include:

A. Overseeing, monitoring, and serving as the focal point for the CRS compliance program with the authority to review all documents and

functions as they relate to fraud and abuse prevention, detection, and reporting,

B. Maintaining a tracking log, with elements as specified by ADHS Compliance Officer, of all potential fraud and abuse issues for tracking and trending;

C. Having authority to independently refer potential member and provider fraud and abuse cases to AHCCCS-OPI and ADHS Compliance Officer;

D. Having direct access to senior management and legal counsel;

E. Providing training for employees, members, and providers which addresses fraud and program abuse prevention, recognition, and reporting and encourages them to report fraud and abuse without fear of retaliation:

1) Sign-in sheets must be maintained for all training sessions; and

2) Fraud and abuse training shall be incorporated into new employee orientation.

F. Attending quarterly ADHS Compliance Officer workgroup meetings held for the purpose of:

1) Discussing compliance issues arising during the previous quarter;

2) Examining new/emerging fraud and program abuse related subjects;

3) Discussing and developing methods for use within the CRS Program to detect and reduce specific types of fraud and program abuse; and

4) Receiving fraud and program abuse related training.

G. Establishing and maintaining a fraud and program abuse hotline. The hotline should allow for anonymous tips and information and should be assessable 24-hours a day, seven days a week (24/7 access does not mean live staffing ï electronic messages and e-mail would be adequate).

H. Attending fraud and abuse training provided by ADHS.

80.900 Business Continuity and Recovery Plan

1. By October 1st of each year, staff from each CRS Regional contractor shall submit their Business Continuity and Recovery Plans to CRSA.

2. The CRS Regional Contractors shall include in their Business Continuity and Recovery Plans planning and training for all the elements as defined and listed in the Business Continuity and Recovery Plan policy (Policy 104 of the AHCCCS Contractor Operations Manual) including:

A. Electronic/telephonic failure at the CRS facility;

B. Loss of primary computer system/records or networks;
C. Complete loss of use of the main site and any satellite sites;
D. Healthcare/CRS facility closure/Loss of a major CRS provider;
E. Arranging for medically necessary covered services for CRS members should the CRS facility become temporarily insufficient;
F. Communication with CRSA in the event of a business disruption;
G. Communication with key customers related to a business disruption;
H. Staff training on the Business Continuity and Recovery Plan; and
I. Periodic testing of the Business Continuity and Recovery Plan, at least annually.

3. The CRS Regional Contractors shall include their Business Continuity and Recovery Plan Required documentation of the following critical processes:
   A. Eligibility and Enrollment;
   B. Scheduling;
   C. Clinic Visits;
   D. Prior-Authorization;
   E. Surgeries;
   F. Utilization Review/Concurrent Review;
   G. Claims/Provider Payments; and
   H. Grievance/Appeals and Quality of Care Concerns.
4. CRS regional contractors are required to notify CRSA of business continuity disruptions. Notification should include the following:
   A. Description of the disruption;
   B. Plans for dealing with the disruption (for example, how you will reschedule clinic visits/surgeries);
   C. Notification timeline: within 24 hours or next business day if on a weekend;
   D. Form of notification: telephone followed in writing via letter to the Division Chief for Compliance at CRSA, (602) 542-1860, 150 N. 18th Avenue Suite #330; Phoenix, AZ 85007-3243; and
   E. Some examples of disruption notification: loss of major provider; floods, loss of air conditioning, phone or computer system down time of greater than two days.
5. CRS Regional contractors will maintain and submit to CRSA education tracking forms and sign-in sheets for Business Continuity and Recovery Plan training provided.
6. By October 1st of each year the CRS Regional Contractors shall submit to CRSA the plan for testing their Business Continuity and Recovery Plan detailing timeline for testing and what will be tested. Documentation of the testing performed by the CRS Regional Contractors shall be submitted to CRSA annually upon completion.

80.1000 CRS Contractor Employee Training Requirements

CRS Contractor employees must participate in appropriate training and educational opportunities within ninety (90) days of their start date in order to effectively meet the requirements of the ADHS/CRSA service delivery system. ADHS/CRSA requires that CRS Contractor staff and providers receive specific training with the intended purpose of meeting the following goals:

1. To promote a consistent family-centered practice philosophy;
2. To assist CRS Contractors in developing a qualified, knowledgeable, and culturally competent workforce; and
3. To ensure that services are delivered with the family-centered philosophy that reflects the vision and mission of the CRS Program.

80.1001 General Orientation and Annual Training Requirements

1. At a minimum, the additional following content areas should be covered in CRS Contractorôs new employee orientation:
   a. CRS Program Overview;
   b. Grievances and Appeals processes;
   c. Quality of Care process;
   d. Notice of Action;
   e. Transition Planning;
   f. Member Rights; and
   g. Coordination of Care.

2. At a minimum, the following content areas must be covered in new employee orientation and annually thereafter:
   a. Cultural Competency, which should include:
      i. Culturally and Linguistically Appropriate Services (CLAS) Standards;
      ii. Cultural Competency terms;
      iii. Principles of family-centered care;
      iv. Use of interpretation and language assistance services;
      v. Limited English Proficiency (LEP);
      vi. TDD/TTY and other Americans with Disabilities Act (ADA) accommodations;
      vii. Grievances and provisions of culturally appropriate care; and
      viii. Creating awareness concerning children and their families health related benefits, attitudes, values, and behaviors and incorporating them into practice.
   b. Corporate Compliance (Fraud and Program Abuse), which should cover content area detailed in Section 80.800; and
   c. Business Continuity and Recovery Plan.

80.1002 Required Training Specific to Provider Service Representatives

The following content areas must also be included in the orientation and training program for provider service representatives or any personnel responsible for providing policy and procedure clarifications and assistance to providers:

1. Claims processing;
2. Prior-authorizations; and
3. Claim disputes process.

80.1003 CRSA's Learning Management System (LMS)

ADHS/CRSA provides many trainings through the LMS, an e-learning environment. To participate in trainings via LMS, participants must first register to receive access to LMS by contacting the E-Learning Program Manager at CRSA at (602) 542-1860.

80.1004 CRSA Training Catalog and Training Requests

ADHS/CRSA will maintain a catalog of trainings available to contractor staff and their providers. The trainings will be available through the Learning Management System (LMS), face to face, and/or video conference. The training catalog is available on the ADHS/CRSA web page. Trainings included in the catalog are:

1. Cultural Competency;
2. Fraud and program abuse;
3. Grievance and Appeals processes;
4. Quality of Care process;
5. Notice of Action;
6. Business Continuity and Recovery Plan;
7. Transition Planning;
8. Member Rights, and
9. Coordination of Care.

CRSA will assess the need for other training topics on an on-going basis.

Attachment 1

Quality of care acknowledgment letter *(On Regional Contractor letterhead)*

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Date

(Name of person filing the grievance)
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS # if applicable)*

Dear *(Name)*:

(Phoenix, Tucson, Flagstaff, Yuma) Childrenôs Rehabilitation Services at the (Phoenix, Tucson, Flagstaff, Yuma address), has received your concerns related to care you have been requesting for your son/daughter through CRS.

(Phoenix, Tucson, Flagstaff, Yuma) CRS clinic will research and respond to this issue. Be assured this issue will be given full consideration. A written response will be sent when the research into this issue has been completed.

This information will be kept confidential under 42 CFR 434.34, ARS 8-546.11(C)(11), ARS 36-2401, et seq., ARS 36-445, and ARS 41-1959C(5).

Thank you for contacting CRS regarding this issue. The quality of health care of all of our members is important to us. You can contact XXXXXXXXX, Quality Management Manager at (XXX) XXX-XXXX if you have any questions regarding this issue.

Sincerely,

*Name and credentials*XXXXXXXXXX
Title

Attachment 2

Quality of care resolution letter (On Regional Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Date

(Name of person filing the grievance
Address
City, State, Zip)

RE: *(CRS Member # & AHCCCS # if applicable)*

Dear *(Name)*:

(Phoenix, Tucson, Flagstaff, Yuma) Children's Rehabilitation Services has completed its review related to XXXXXXXXXXXXXXXXXX.

Provide explanation in lay person's terms
This information will be kept confidential under 42 CFR 434.34, ARS 8-546.11(C)(11), ARS 36-2401, et seq., ARS 36-445, and ARS 41-1959C(5).

Thank you for contacting CRS regarding this issue. The quality of health care of all of our members is important to us. You can contact XXXXXX, at (XXX) XXX-XXXX if you have any questions regarding this issue.

Sincerely,

Name and credentials
Title

Attachment 3

QUALITY OF CARE CONCERN SEVERITY LEVELS

Level 0- Track only:

No risk for it to be a quality of care concern, risk of harm, permanent damage, increased cost of care, lengthened stay, permanent damage, or potential media event. Concerns may be related to physical elements of the clinic and discourtesy.

Level 1- Concern that MAY impact the member if not resolved:

Potential unsafe home environment; non-compliance with appointment scheduling or wait time requirements; need for information or referral to resolve an issue.

Level 2- Concern that WILL impact the member if not resolved:

Including slow, or no responsiveness to a request for evaluation, treatment other request; member rights violation; inadequate case management; physician clinic cancellations; availability/timeliness of transportation for medical appointments.

Level 3- Concern that IMMEDIATELY impacts the member and is considered life threatening or dangerous

Including situations of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of an acute condition; denial of services deemed medically necessary by the member/provider; potential provider misconduct; issues with, or the potential for, adverse media coverage or the potential for a lawsuit; and issues referred by the AHCCCS Director's Office.

Level 4- Concern that no longer impacts the member but may have potential to be life threatening or dangerous to other members:

Unexpected death has resulted, directly or indirectly as a result of care given or omitted. Media coverage assured. Lawsuit filed or in process.

Examples include cases abuse and neglect; unexpected deaths; and cases from the Governor's Office, Legislature, or ADHS Director/Assistant Director's Office regardless of the nature.

Attachment 4

Quality of Care Categories

MAIN CATEGORY	SUB-CATEGORY
Availability, Accessibility & Adequacy (AAA)	Specialty selection
Availability, Accessibility & Adequacy (AAA)	Specialty change
Availability, Accessibility & Adequacy (AAA)	Access to services
Availability, Accessibility & Adequacy (AAA)	Access to specialists
Availability, Accessibility & Adequacy (AAA)	Adequacy of provider network
Availability, Accessibility & Adequacy (AAA)	Appointment availability
Availability, Accessibility & Adequacy (AAA)	Delay in referral
Availability, Accessibility & Adequacy (AAA)	Delay in treatment/service
Availability, Accessibility & Adequacy (AAA)	Provider refusal to provide care
Availability, Accessibility & Adequacy (AAA)	Telephone access
Availability, Accessibility & Adequacy (AAA)	Transportation
Availability, Accessibility & Adequacy (AAA)	DME
Availability, Accessibility & Adequacy (AAA)	Enviromental Modifications
Availability, Accessibility & Adequacy (AAA)	Other
Effectiveness/Appropriateness of Care	Inappropriate treatment
Effectiveness/Appropriateness of Care	Treatment is ineffective or below medical standards
Effectiveness/Appropriateness of Care	Non-formulary medications
Effectiveness/Appropriateness of Care	Missed diagnosis
Effectiveness/Appropriateness of Care	Dietary services inappropriate
Effectiveness/Appropriateness of Care	Skin integrity
Effectiveness/Appropriateness of Care	Access to medical care
Effectiveness/Appropriateness of Care	Delay in providing medical records or treatment plan to PCP
Effectiveness/Appropriateness of Care	Inappropriate transfer
Effectiveness/Appropriateness of Care	Inappropriate discharge
Effectiveness/Appropriateness of Care	Other
Safety/Risk Management	Pharmacy Prescription error
Safety/Risk Management	Injury/accident
Safety/Risk Management	Unsafe enviroment
Safety/Risk Management	Poor operation or conditions (DME)
Safety/Risk Management	Documentation/medical record
Safety/Risk Management	Altered medical records
Safety/Risk Management	Discharge AMA
Safety/Risk Management	Receipt of services AMA
Safety/Risk Management	Unexpected death
Safety/Risk Management	Other

Member Rights/Respect and Caring	Continuity of caring
Member Rights/Respect and Caring	Coordination of care
Member Rights/Respect and Caring	Advance directives
Member Rights/Respect and Caring	Disrespectful/unprofessional conduct by provider
Member Rights/Respect and Caring	Disrespectful/inappropriate conduct by member
Member Rights/Respect and Caring	Not including member/parent in plan of care
Member Rights/Respect and Caring	Member dissatisfaction with treatment plan or care provided
Member Rights/Respect and Caring	Physical abuse
Member Rights/Respect and Caring	Physical neglect
Member Rights/Respect and Caring	Emotional abuse
Member Rights/Respect and Caring	Culturally insensitive
Member Rights/Respect and Caring	Restraints-physical
Member Rights/Respect and Caring	Restraints-chemical
Member Rights/Respect and Caring	Denial letter(s) not provided
Member Rights/Respect and Caring	Reduction in service letter(s) not provided
Member Rights/Respect and Caring	No access to medical records
Member Rights/Respect and Caring	No grievance process information provided
Member Rights/Respect and Caring	Other
Denial, Decrease or Discontinuance of Covered	Denial of services- not medically necessary
Denial, Decrease or Discontinuance of Covered	Denial of services- no prior authorization
Denial, Decrease or Discontinuance of Covered	Denial of services-not a covered service
Denial, Decrease or Discontinuance of Covered	Denial of services-eligability
Denial, Decrease or Discontinuance of Covered	Denial of services payer of last resort
Denial, Decrease or Discontinuance of Covered	Decrease in the amount of service previously provided
Denial, Decrease or Discontinuance of Covered	Discontinuance of service provided
Denial, Decrease or Discontinuance of Covered	Discontinuance of previously covered benefit
Denial, Decrease or Discontinuance of Covered	Other
Fraud (i.e., by a member, a provider, or financial)	Referrals to entities in which the provider or family member has a financial interest
Fraud (i.e., by a member, a provider, or financial)	Inappropriate billing
Fraud (i.e., by a member, a provider, or financial)	Inappropriate use of covered benefit
Fraud (i.e., by a member, a provider, or financial)	Use of service by someone other than an enrolled member
Fraud (i.e., by a member, a provider, or financial)	Altered medical record due to fradulant action

Attachment 5

(*Regional Contractor Letterhead)*

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at *(code)-phone* # and someone will assist you.

NOTICE OF ACTION

Date

To: Name
Address
City, State Zip

From:

You have asked that **INSERT**: Name of the Contractor approve: **INSERT**: Describe services requested on behalf of the member in easily understood terms. We have reviewed your request and decided that: **INSERT**: Describe action taken (or intended to be taken) by Contractor, including the relevant dates, in member specific terms and in easily understood language.

Our decision is based on the following reasons**: INSERT:** The explanation of the Contractorôs decision must be complete and in commonly understood language. It must specify the relevant laws, rules, policies, etc. for the action. The explanation must also be both member and fact specific, describing the memberôs condition and the reasons supporting the Contractor decision. Generic statements are not adequate. Any decisions to deny or reduce a service authorization request must be made by a health care professional who has appropriate clinical expertise in treating the memberôs condition or disease.

You can ask us to look at our decision again. This is called an appeal. You can have someone help you appeal. Also, your doctor or other health care provider can appeal for you if you write telling us so. If you appeal you must contact us by **INSERT DATE:** no later than 60 days after the date of this Notice. *You can write or call us to appeal*. If you write your appeal, it must be received by **INSERT DATE**: 60 days from the date of the Notice.

Before we make our decision, you can give us any information that you think will be helpful. You can ask to set up a meeting so that you can give us the information in person, or you can give it to us in writing. You can also see your case file, including medical records and other information about your appeal, before you give us information and before we decide the appeal. After we review your appeal, we will send you our decision in writing. This decision is called the Notice of

Appeal Resolution.

We will make a decision within 30 days. However, you may ask for a faster review of your appeal. This is called an "expedited appeal." You can ask for a faster review if your/your child's life or health could be in danger or your/their ability to attain, maintain or regain maximum function would be damaged by waiting the normal 30 days for a decision on your appeal. If your health care provider tells us this, the appeal will be decided in 3 working days. You may also ask us to decide the appeal in 3 working days. If you ask us yourself and we agree, we will make a decision in 3 working days. If you ask for a faster review (expedited appeal), tell us how your health will suffer if we take 30 days to decide your appeal. If we do not agree that a faster review is needed, we will write you within 2 days, and we will also try to call you. Then we will decide your appeal within 30 days.

For all appeals, up to 14 more days may be taken to make a decision on your case. This is called an extension. If we want an extension we will tell you why it is needed. If you want an extension, you can you can ask for it by writing or calling us.

TO REQUEST CONTINUED BENEFITS DURING THE INSERT: Name of Contractor APPEALS PROCESS

You can ask that the services listed in this letter continue while we make a decision. If you want those services to continue, you must say so when you appeal. This applies if we are stopping or reducing an approved service ordered by your doctor or other health care provider that you are receiving now. This also applies to a service we have denied if the doctor or other health care provider says that the service is a necessary continuation of a service that was approved before. Your service will only be continued if you appeal by **INSERT DATE:** (the later of: 10 days from the date of the Notice OR the intended date of the action). If you do not win your appeal, you will be responsible for paying for these services provided during the appeal.

If you have any questions about filing an appeal or if you need help, you can call us at **INSERT**: phone number. Please send your written appeal to**: INSERT:** address.

Sincerely,

INSERT: Signature of Medical Director

INSERT: Name of Medical Director

cc. AHCCCS Plan
PCP/provider
CRSA
Chart copy

Attachment 5

(*Usar Papel de Membrete del Contratista Regional de CRS*)

Si usted tiene dificultades leyendo este aviso porque las -letras son demasiado pequeñas 0 las palabras son muy difícil para leer, favor de llamarnos y alguien le asistirá.
(Code)-Phone # or (800) --- ---
http://www.ahcccs.state.az.us/Regulations/OSPPolicy/default.asp

Aviso de Acción

Fecha

A: Nombre
Dirección
Ciudad, Estado, Código Postal

De:

Usted ha pedido que **PONER:** Nombre del Contratista apruebe: **PONER:** En términos fáciles de entender, describa los servicios que fueron solicitados a nombre del miembro. Se ha revisado su petición y se decidió esto: **PONER:** Describa la acción tomada (o que intenta ser tomada) por el Contratista, incluyendo las fechas relevantes, en términos específicos para el miembro y en un lenguaje fácil de comprender.

Nuestra decisión esta basada en las siguientes razones: **PONER:** La explicación de la decisión del Contratista debe ser completa y en un lenguaje comúnmente entendible. Debe especificar las leyes relevantes, las reglas, las pólizas, etc. para la acción. Esta explicación debe especificar los hechos y también ser concreta para el miembro, describiendo la condición del miembro y las razones apoyando la decisión tomada por el Contratista. Las declaraciones genéricas no son adecuadas. Cualquier decisión de negar o reducir una solicitud para la autorización del servicio debe ser hecha por un profesional del cuidado de la salud que tiene pericia clínica apropiada para tratar la condición o enfermedad del miembro.

Usted puede pedir que la decisión sea revisada nuevamente. Esto se llama una apelación. Usted puede obtener ayuda de otra persona con su apelación. También, su doctor u otro proveedor de cuidado de salud pueden hacer una apelación por parte suya, si usted nos deja saber por escrito que eso va pasar. Si usted decide hacer una apelación tiene que avisarnos en **PONER FECHA:** a no más tardar 60 días después de la fecha de este Aviso. *Usted puede hacer su apelación enviándonos una carta o hablándonos por teléfono.* Si usted decide escribir su apelación, debe de ser recibida para **PONER FECHA:** 60 días desde de la fecha de este Aviso.

Antes de que se tome una decisión usted puede dar cualquier información que crea que sea beneficiosa. Usted puede pedir que se haga una reunión, para darnos la información en persona, o puede enviar la información por escrito. Antes de tomar una decisión sobre su apelación, y antes de darnos información adicional, usted tiene el derecho de revisar su archivo, incluyendo los expedientes médicos y otra información sobre su apelación. Después de revisar su apelación, se le enviará la decisión por escrito. Esta decisión se llama Aviso de la Resolución de la Apelación.

Tomaremos una decisión en un plazo de 30 días. Sin embargo, usted puede pedir una revisión más rápida para su apelación. Esto se llama ñApelación Aceleradaò.
Usted puede solicitar una revisión mas rápida si su salud o su vida/o la de su hijo(a) estuviera en peligro o si la capacidad de usted/ellos de lograr, mantener o la recuperación de la función normal se deteriorara, por esperar los 30 días que normalmente se puede tomar para hacer una determinación por su apelación. Si su proveedor de cuidado de salud nos informa que esto puede suceder, la apelación será decidida dentro de 3 días laborales. Usted también tiene el derecho de pedirnos que tomemos una determinación sobre su apelación dentro de 3 días laborales. Si usted mismo nos pide tomar una decisión más rápida y si estamos de acuerdo, tomaremos una decisión en 3 días laborales. Si usted pide una revisión más rápida (apelación acelerada), explíquenos como sufrirá su estado de salud, si nos tardamos los 30 días para hacer una decisión para su apelación. Si no estamos de acuerdo que se necesita hacer una revisión rápida, le avisaremos por medio escrito dentro de 2 días, y también trataremos de hablarle por teléfono. Luego decidiremos dentro de los 30 días sobre su apelación.

Para todas las apelaciones, 14 días más pueden ser tomados para hacer una decisión sobre su caso. Esto se llama una extensión. Si queremos una extensión le explicaremos por qué es necesario. Si usted quiere una extensión, puede pedirlo, llamándonos por teléfono o escribiéndonos.

PARA SOLICITAR QUE SUS BENEFICIOS CONTINUEN DURANTE EL PROCESO DE APELACIÓN DE <u>PONER: Nombre de Contratista</u>

Usted puede pedir que los servicios mencionados en esta carta continúen mientras llegamos a una decisión. Si usted quiere que los servicios continúen, debe decirlo cuando haga su apelación. Esto se aplica cuando reducimos o terminamos los servicios aprobados y ordenados por su doctor u otro proveedor de salud que usted esta recibiendo en este momento. También esto se aplica para los servicios que le hemos negado, si su doctor u otro proveedor de salud dice que el servicio necesitado es una continuación de un servicio que fue aprobado antes. Su servicio será continuado solamente, si usted solicita una apelación en **PONER FECHA:** <u>(No mas tardar: 10 días a partir de la fecha del aviso ó de la fecha prevista de la acción)</u>. Si usted no gana su apelación, usted será responsable en pagar los servicios proveídos durante su apelación.

Si usted necesita ayuda o tiene preguntas sobre como solicitar una apelación, nos puede llamar al **<u>PONER:</u>** <u>numero de teléfono.</u> Envié por favor su apelación escrita al: **<u>PONER:</u>** <u>dirección.</u>

Respetuosamente,

PONER: Firma del Director Médico

PONER: Nombre del Director Médico

dd. Plan de AHCCCS
Doctor/proveedor
CRSA
Copia de archivo (not the translation of chart copy, instead it states copy of archives)

Attachment 6

(On Regional Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.
XXX-XXX-XXXX or (800) XXX-XXXX

Notification of Extension for Service Authorization Timeframe

Date

Name of Member/Guardian
Address
City, State, Zip)

RE: *(CRS Member Name, Member # & AHCCCS #)*

Dear *(Name)*:

We are requiring an extension in the review and approval/denial of your requested (*identify the service).* It may take up to fourteen extra days for the processing of your requested service. In no case will this process take more than 28 days from the date we received the request from your provider. Please call if you have any questions, at XXX-XXX-XXXX, and we will be happy to help you with the call.

On behalf of (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding.

If you disagree with our extension of the timeframes, you can make a grievance. You may contact us at INSERT CONTACT NUMBER FOR ORAL GRIEVANCES or you can send a written grievance to INSERT ADDRESS.

If you need help with making a complaint [insert local advocacy organizations] For more information about this notice, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the service authorization process.

Sincerely,

XXXXXXXXXXX
Name and credentials
Title

Cc:
Requesting Provider
ALTCS/Acute Care Provider

Attachment 6

(Usar Papel de Membrete del Contratista Regional de CRS)

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difíciles de leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Notificación de la Extensión del Horario Para Autorizaciones De Servicios

Fecha

Nombre de Miembro/Guardián
Dirección
Ciudad, Estado, Código Postal

De: *(Nombre de Miembro, # miembro de CRS e # identificación de AHCCCS)*

Estimado *(Nombre)*:

Estamos requiriendo una extensión en la revisión y la aprobación/negación en su solicitud (identifique el servicio). Puede tomar hasta catorce días adicionales para procesar el servicio solicitado. En ningún caso éste proceso tomará más de 28 días a partir de la fecha que recibimos la petición de su proveedor. Por favor llame si usted tiene cualquier pregunta, al XXX-XXX-XXXX, y estaremos complacidos de ayudarle con su llamada.

Por parte de (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, gracias por su paciencia y comprensión.

Si usted no está de acuerdo con el horario de nuestra extensión, usted puede presentar una queja. Usted puede comunicarse con nosotros al PONER NUMERO DE CONTACTO PARA QUEJAS ORALES o usted puede enviar su queja escrita en PONER DIRECCION.

Si usted necesita ayuda para presentar una queja, [inserte organizaciones de ayuda local o legal.] Para más información sobre este aviso, usted puede comunicarse con la persona de quién el nombre y dirección aparece en la parte superior de este aviso. Usted también se puede referir al manual de los miembros para más información sobre el proceso de la autorización de servicios.

Sinceramente,

XXXXXXXXXXX
Nombre y credenciales
Titulo

Cc:
Proveedor solicitante

Attachment 7

(CRS Regional Contractor Letterhead)

Notice to ALTCS/Acute Care Contractor of Non-Coverage by Children's Rehabilitative Services

To (ALTCS/Acute Care Contractor)

Date:

Re: *(Member name, CRS #, AHCCCS #)*

A CRS provider or member has asked that (*name of CRS clinic*) approve: *(describe services including date requested)*

The *(name region*) CRS Regional Medical Director has reviewed and denied the requested service as not covered by CRS.

This decision is based on the following: *(Any decisions to deny or reduce a service must be made by a physician, who has appropriate clinical expertise in treating the member's condition or disease. The explanation must be complete and specify the relevant laws, rules, policies etc. for the action. The explanation must also be both member and fact specific, describing the member's condition and the reasons supporting the denial.)*

If you disagree with this decision, you have the right to appeal the decision and file a Request for Review in writing with the CRS Regional Medical Director no later than 10 business days after receipt of this notice.

Sincerely,

_____

Medical Director

Cc: Requesting Physician/Provider
File copy
CRSA

Attachment 7

(*Usar Papel de Membrete del Contratista Regional de CRS*)

Aviso al Contratista del Programa de ALTCS/Acute Care No Proporcionar Cobertura de Servicios por parte de CRS

A: Nombre del Contratista

Fecha:

Acerca de: (Nombre del miembro, # miembro de CRS e # identificación de AHCCCS)

Un proveedor de CRS o un miembro de CRS ha pedido que (*nombre de la clínica de CRS*) apruebe: (*describa los servicios solicitados, incluyendo la fecha que fueron solicitados*).

El Director Regional Médico de CRS (*nombre de la región*) ha revisado y negado el servicio solicitado por que no es un servicio que esta cubierto por CRS.

Esta decisión se basa en lo siguiente: *(Cualquier decisión para negar o para reducir un servicio debe ser hecha por un médico, el cual tiene pericia clínica apropiada en tratar la condición o la enfermedad del paciente o miembro. La explicación debe ser completa y especificar las leyes relevantes, las reglas y las pólizas, etc. para la acción tomada. Esta explicación debe especificar los hechos y también ser concretamente para el miembro, describiendo la condición del mismo y las razones que apoyen la negación de este servicio.)*

Si usted no esta de acuerdo con esta decisión, tiene el derecho de apelar la decisión y someter por escrito una Solicitud para Revisión al Director Regional Médico de CRS, a no mas tardar 10 días laborales después de recibir esta carta.

Sinceramente,

_____

Director Médico

C.C: Solicitud enviada por parte del Doctor/Proveedor

Copia de Archivo
CRSA

Attachment 8

(CRS Regional Contractor Letterhead)

Notice of Decision by CRS
on
ALTCS/Acute Care Contractor Request for Review

Date

To: ALTCS/Acute Care Contractor Name
Address

Re: (*Member name, CRS Member # and AHCCCS ID#*)

Dear: (*Plan Medical Director*)

We received your Request for Review dated _____ asking us to review our decision to _____.

After reviewing our original decision, we have decided (*that the first decision was right/* ***or****/ to change our decision to* _____.) We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you may file a request for a hearing with the AHCCCS Administration within 30 days of receipt of this letter.

If you have questions, please call us at *(XXX) XXX-XXXX.*

Sincerely,

_____
CRS Regional Medical Director

Attachment 8

(Usar Papel de Membrete del Contratista Regional de CRS)

Aviso de la Decisión por CRS sobre su Solicitud para una Revisión para el Plan de Salud AHCCCS/Contratista del Programa

Fecha

A: Nombre del Plan de Salud
Dirección

Re: *(Nombre del miembro, # miembro de CRS e # identificación de AHCCCS)*

Estimado: *(Director Médico del Plan)*

Hemos recibido su solicitud para una revisión, con fecha _____, pidiéndonos considerar nuestra decisión sobre_____.

Después de examinar la decisión original, se ha determinado *(que la primera decisión estaba correcta o/ cambiar nuestra decisión a _____.)* Se ha tomado ésta medida basado en lo siguiente *(Incluya por favor las citaciones legales o las autoridades que apoyen la determinación.)*

Si usted no esta de acuerdo con nuestra decisión, puede solicitar una audiencia con la Administración de AHCCCS dentro de los 30 días siguientes a que reciba esta carta.

Si usted tiene preguntas, favor de llamarnos al *(XXX) XXX-XXXX*.

Sinceramente,

_____
Director Médico Regional de CRS

Attachment 9

Notice to AHCCCS Health Plan/Program Contractor of Non-Coverage by Children's Rehabilitative Services

To (AHCCCS Plan name)

Date:

Re: (Member Name, CRS #, AHCCCS #)

A CRS provider or member has asked that (*name of CRS clinic*) approve: (*describe services including date requested*)

The (*name region*) CRS Regional Medical Director has reviewed and denied the requested service as not covered by CRS.

This decision is based on the following: (*Any decisions to deny or reduce a service must be made by a physician, who has appropriate clinical expertise in treating the member's condition or disease. The explanation must be complete and specify the relevant laws, rules, policies etc. for the action. The explanation must also be both member and fact specific, describing the member's condition and the reasons supporting the denial.*)

If you disagree with this decision, you have the right to file a Request for Review in writing with the CRS Regional Medical Director no later than 10 business days after receipt of this notice.

Sincerely,

_____
Medical Director

cc: Requesting Physician/Provider
File copy
CRSA

Attachment 9

(*Usar Papel de Membrete del Contratista Regional de CRS*)

Aviso de la Decisión por CRS sobre su Solicitud para una Revisión para el Plan de Salud AHCCCS/Contratista del Programa

Fecha

A: Nombre del Plan de Salud
Dirección

Re: (Nombre del miembro, # miembro de CRS e # identificación de AHCCCS)

Un proveedor de CRS o un miembro de CRS ha pedido que (*nombre de la clínica de CRS*) apruebe: (*describa los servicios solicitados, incluyendo la fecha que fueron solicitados*).

El Director Regional Médico de CRS (*nombre de la región*) ha revisado y negado el servicio solicitado por que no es un servicio que esta cubierto por CRS.

Esta decisión se basa en lo siguiente: *(Cualquier decisión para negar o para reducir un servicio debe ser hecha por un médico, el cual tiene pericia clínica apropiada en tratar la condición o la enfermedad del paciente o miembro. La explicación debe ser completa y especificar las leyes relevantes, las reglas y las pólizas, etc. para la acción tomada. Esta explicación debe especificar los hechos y también ser concretamente para el miembro, describiendo la condición del mismo y las razones que apoyen la negación de este servicio.)*

Si usted no esta de acuerdo con esta decisión, tiene el derecho de apelar la decisión y someter por escrito una Solicitud para Revisión al Director Regional Médico de CRS, a no mas tardar 10 días laborales después de recibir esta carta.

Sinceramente,

_____
Director Médico Regional de CRS

C.C: Solicitud enviada por parte del Doctor/Proveedor
Copia de Archivo
CRSA

Attachment 10

(On Regional Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Notification of Extension for Referral to ALTCS/Acute Care Contractor

Date

Name of Member/Guardian
Address
City, State, Zip)

RE: *(CRS Member Name, Member # & AHCCCS #)*

Dear *(Name)*:

We are forwarding your request for (*identify the service)* to your AHCCCS Plan. It may take up to fourteen extra days for your Plan to receive and process the request. In no case will this process take more than 28 days from the date we received the request from your provider. Please call your AHCCCS Plan if you have any questions, or, if you do not know who to contact at your AHCCCS Plan, please call us at XXX-XXX-XXXX, and we will be happy to help you with the call.

On behalf of (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding.

If you disagree with our extension of the timeframes, you can make a grievance. You may contact us at INSERT CONTACT NUMBER FOR ORAL GRIEVANCES or you can send a written grievance to INSERT ADDRESS.

If you need help with making a complaint [insert local advocacy organizations] For more information about this notice, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the service authorization process.

Sincerely,

XXXXXXXXXXX

Name and credentials
Title

Cc:
Requesting Provider
ALTCS/Acute Care Contractor

Attachment 10

(Usar Papel de Membrete del Contratista Regional de CRS)

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difíciles de leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

Notificación de la Extensión para la Remisión al ALTCS/Acute Care Contractor

Fecha

Nombre de Miembro/Guardián
Dirección
Ciudad, Estado, Código Postal

De: *(Nombre de Miembro, # miembro de CRS e # identificación de AHCCCS)*

Estimado *(Nombre)*:

Hemos enviado su petición para (*identifique el servicio*) a su plan de AHCCCS. Puede tomar hasta catorce días adicionales para que su Plan reciba y procese la petición. En ningún caso este proceso tomara más de 28 días a partir de la fecha que recibimos la petición de su proveedor. Por favor llame a su plan de AHCCCS si tiene cualquier pregunta, o, si no sabe con quién comunicarse al plan de AHCCCS, por favor llame al XX-XXX-XXXX, y estaremos complacidos de ayudarle con su llamada.

Por parte de (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, gracias por su paciencia y comprensión.

Si usted no está de acuerdo con el horario de nuestra extensión, usted puede presentar una queja. Usted puede comunicarse con nosotros al PONER NUMERO DE CONTACTO PARA QUEJAS ORAL o usted puede enviar su queja escrita a PONER DIRECCION.

Si usted necesita ayuda para presentar una queja, [inserte organizaciones de ayuda locales o legales.] Para más información sobre este aviso, usted puede comunicarse con la persona de quién el nombre y dirección aparece en la parte superior de este aviso. Usted también se puede referir al manual de los miembros para más información sobre el proceso de la autorización de

servicios.

Sinceramente,

XXXXXXXXXXX
Nombre y credenciales
Titulo

Cc:
Proveedor Solicitante
Contratista de ALTCS/Acute Care